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Substance Abuse and Mental Health Services Administration

53rd Meeting
of the
SAMHSA National Advisory Council (NAC)

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PROCEEDINGS

Agenda Item: Call the 53rd SAMHSA NAC Meeting to Order

MS. PAMELA S. HYDE: Good morning, everyone. Good to have everybody here. We have quite a few new members. We're going to give a chance to everybody to introduce themselves in a moment, but we're going to start, I think, Geretta, with getting the minutes dealt with, I believe?

MS. GERETTA WOOD: Well, actually, I have a few announcements before we begin.

MS. PAMELA S. HYDE: Okay. Why don't you do that?

MS. GERETTA WOOD: Please silence your electronic devices and remember to speak into the microphone so that those listening on the phone can hear you clearly. Council member Lorrie Rickman Jones will be joining us by telephone.

And I would like to remind you if you have honorarium forms, if you would give those to me before lunch, I would really appreciate it. We'll be able to expedite payment for you. Those are, by the way, in the last tab of your notebook today.

I note for the record that the voting members present constitute a quorum, and I now turn the meeting over to Pamela Hyde.

Agenda Item: Welcome and Opening Remarks

MS. PAMELA S. HYDE: Thanks, Geretta.

And I do want to remind you about the microphones. We have to keep reminding people about those, including myself. The main thing is not only turn them on when you're using them, but turn them off when you're not because it makes the other microphones work better.

So welcome to everybody.

Arturo Gonzales, who is one of our members, did indicate to us right before the meeting that he had that awful flu that's going around, chose not to get on a plane, which I think was a good thing. So I don't know if he's even joining by phone today.

MS. GERETTA WOOD: He indicated that if he was feeling better, he would.

MS. PAMELA S. HYDE: Okay. So we may have him on or not, but we do have several new folks. So let's start by going around and having people introduce themselves and just say where you're from and why you're here and why you care and all that good stuff.

MS. DEE DAVIS ROTH: I'm Dee Roth. I'm from Ohio. For 36 1/2 years, I was in charge of evaluation and research for the Ohio Department of Mental Health, and I care about this stuff a lot.

MR. CHARLES OLSON: I'm Charlie Olson. I'm from Minnesota. I guess I'm here because I'm open to advocate for consumers of mental health a little bit better.

MS. PAMELA S. HYDE: Hang on just a minute, Ben.

Irene, did you need something?

MS. IRENE GOLDSTEIN: If you could speak more into the microphone?

MS. PAMELA S. HYDE: Okay. All right. So we need people to speak up. Even though this is a small room, they're recording things, and the folks on the line have to hear.

So, Ben?

DR. BENJAMIN SPRINGGATE: I'm Ben Springgate. I'm a general internist from New Orleans. I have done some work in mental health services research in academic settings, and I'm in private practice in general internal medicine and serve as medical director of some faith-based clinics serving uninsured in New Orleans.

MS. ELIZABETH A. PATTULLO: Good morning. I'm Betsy Pattullo, and I'm the founder and chairman of Beacon Health Strategies, which is a managed behavioral health care company now doing business with primarily Medicaid health plans across the country. And I was delighted to be invited to join the National Advisory Council. I'm very proud to say I have a son who's about to celebrate 7 years of being clean and sober, and it's nice to have the miracle in our family.

MS. CASSANDRA PRICE: Good morning. My name is Cassandra Price. I am the Single State Authority or Director for the Division of Addictive Diseases at the Department of Behavioral Health in Georgia. I also serve on the NASADAD, National Association for State Alcohol and Drug Directors, Region 4 director board.

And happy to be here. Been in the field of addiction for 13 years. I guess that makes me a baby in some ways, but have lots of family members and friends in recovery, and I have a real passion for this field and the work that everyone is just passionate about.

Thank you.

DR. H. WESTLEY CLARK: Westley Clark. I'm the Director of the Center for Substance Abuse Treatment.

DR. PETER J. DELANY: Pete Delany, Director for Center for Behavioral Health Statistics and Quality.

MS. PAMELA S. HYDE: Excuse me just a minute. Those of you on the phone, can you mute your phone so we don't hear the background noise?

Thank you.

MS. FRANCES M. HARDING: Good morning. Fran Harding, the Director for the Center of Substance Abuse Prevention.

MR. PAOLO DEL VECCHIO: Good morning. I'm Paolo del Vecchio, Director of the Center for Mental Health Services.

MR. CHRISTOPHER R. WILKINS: Good morning. Chris Wilkins. I'm founder and chief executive officer of Loyola Recovery Foundation, an organization that works with the VA to serve veterans and VISN 2 in New York State, which is everything except New York City.

I'm here to participate and to support SAMHSA in what it is doing with veterans and with everyone whose lives we touch. It is very exciting to me that we've entered a time where everybody gets access, everybody gets a chance, everybody gets help. And that's a mindset that's worth working hard on.

So, thank you.

DR. STEPHANIE M. LE MELLE: Stephanie Le Melle. I'm a community psychiatrist. I'm the Co-Director of Public Psychiatry Education at Columbia Department of Psychiatry in New York.

My interest is on the interface between law and psychiatry and the implications that that has for community psychiatry. And I think from that perspective, everything that SAMHSA does is dear to my heart and to the folks that I treat in the communities in New York City.

DR. MARLEEN WONG: Good morning. I'm Marleen Wong, currently Associate Dean of the School of Social Work at the University of Southern California and previously the Director of School Mental Health, Crisis Intervention, and Suicide Prevention Programs in the Los Angeles Unified School District.

MS. MEGAN GREGORY: Good morning. My name is Megan Gregory. I am currently the community project coordinator at Southeast Alaska Regional Health Consortium, and I also work with the Center for Native American Youth as a board member, which former Senator Byron Dorgan created 2 years ago. And I recently joined the National Council of Young Leaders through YouthBuild USA.

So I'm passionate because Alaska currently has the highest suicide rates in the Nation, and I'm from a rural community, and I know what it's like to grow up in a small town and feel like you don't have opportunities. So I'm all about promoting great experiences and letting kids know that there are opportunities. It's everywhere, and I just want to be able to reach out and encourage kids to live a healthy, happy life.

Thank you.

MS. JACQUELYN RIVERS: Good morning. Jac Rivers, Special Assistant to the Administrator.

MS. PAMELA S. HYDE: Okay. Thank you.

We have a couple of people helping us over here. Josh Shapiro and Abby Smith, and then Irene is back here taking notes. So they're always quietly in the background doing good work for us. So, thank you.

MS. KANA ENOMOTO: [on telephone] And Pam, this is Kana. I just want to let you know I'm on the phone.

MS. PAMELA S. HYDE: Hey, Kana. Good to have you here. Kana is trying to battle something as well. So she's staying home.

I don't --

MR. RAY HEER: Ray Heer.

MS. PAMELA S. HYDE: Ray, thank you. I also want to acknowledge him, helping to take notes today.

You should have -- I think they have this in their hands. Is that correct? So just there are draft highlights from yesterday. Our good folks around the room helped take these notes, and we had some notes from some of the other committees yesterday. You remember the answer or the question, could we get

that feedback? The problem is those don't get vetted. I mean, they're overnight, but we want to give them to you because we're going to have a conversation this morning about your thoughts from yesterday's conversation.

But before we get to that while the pieces of paper are going around, let me just acknowledge again all the new folks. We're really pleased to have all of you. I am laughingly saying this a lot these days because I used to be, and Dee will remember this, I used to be the kid in the room. I am no longer by a long shot the kid in the room, and I'm loving seeing this youth groups, these youth folks coming up with the passion. So thanks especially to Megan and Charlie for being here.

Don Rosen is another member I forgot to acknowledge that he had other commitments and could not be here today. So we've got a great National Advisory Council now, I believe. And I just also want to acknowledge Paul from one of our other advisory councils is in the room as well. So thank you for coming and listening today.

We also have some staff in the back of the room for those on the phone.

All right. Before we jump into this, Tanya, can you just tell us how many people are on the phone?

OPERATOR: It looks like we have 11.

MS. PAMELA S. HYDE: Okay. Great. Thank you.

All right. So the first thing we usually like to do in this time is just have a few minutes to reflect about yesterday. I do want to acknowledge that the conversation about health reform yesterday was a little different than the other ones we've been having, but it was also very rich and helpful to us to think about in many ways. And I acknowledge that one because we just finished celebrating the third anniversary, believe it or not, of the Affordable Care Act.

So it's hard to believe it's actually been in place for 3 years now. A lot has happened in 3 years, including a lot of stuff that we sometimes keep looking forward so we don't acknowledge kind of some of what it's already done, which is to allow literally millions of young people to be -- to stay on their parents' insurance through age 25, up to age 26 or through age 26. I always get that confused.

But nevertheless, in ways they weren't able to before. That really helps, frankly, young people who -- that we are particularly concerned about right now, that transition age youth group that sometimes loses their access to insurance just as they're entering adulthood. So that's really cool.

There is also millions of young people who have been able to purchase insurance without a preexisting condition exclusion, and that's going to extend to all Americans come January. So those two things, in and of themselves, are important for us. And to the extent that there are people in those groups who have bipolar disorder, depression, ADHD, any number of issues that might have previously prevented them from getting insurance or keeping insurance, it's really cool that that is happening.

In addition to that, you heard yesterday there's lots of work going on, both inside SAMHSA, working with providers and States and others, just trying to help people get ready for the coming enrollment and eligibility issues, and then working with a lot of groups around enrollment and eligibility issues. Specifically focusing, for example, on the criminal justice group. So people coming out of jails and prisons, people working with the homelessness group.

So people in that case it's often the providers or the shelters that are helping people get on insurance. So we really want to work with those providers, and then there are several other groups we could talk about later, if you like, that we're trying to provide some special assistance to over this next few months.

The reason I started there is because I am amazed always at how much we don't know yet as a field and how much we don't realize is coming at us. And I am increasingly struck by how much this could -- this possibility and what's going to happen in the next few months and especially beginning October 1st, when people can literally start signing up for coverage, and then January 1st when that coverage actually starts.

We mentioned yesterday literally 62 million more people are going to have access to behavioral health services. Maybe a little bit or maybe a lot, but nevertheless some that they didn't have before. So that is both a huge opportunity and an incredible challenge.

And Chris, you were very articulate about the anxiety about it yesterday, and I think all of us were sort of struggling with saying, my gosh, there's tons we don't know about what this is going to mean for us as a workforce, as a provider system, as a specialty system, as now having competitors, as all kinds of things. So those will be interesting challenges to deal with.

So it's an interesting time. The other thing I just want to underscore about yesterday's conversation is this whole issue of the White House and the Secretary and the Secretary of Education and others saying Now is the Time to take a look at mental health issues. I can tell you there is active planning going on for the launch of the national dialogue on mental health.

I can also tell you, at least as I see it emerging, that this is not something the White House is expecting to kind of do and then walk away from. They are really

thinking about it as a sustained effort at trying to get the country to think about mental health more broadly.

And again, I think I said it yesterday, but I'll say it just clearly. We are using the term "mental health" in this context because the White House is, in fact, emphasizing mental health at the moment around this, mental health and people with co-occurring disorders. There is other things in their minds and other parts of the White House that focus very heavily on substance abuse, and I had a brief opportunity to talk directly with the President recently in which he was very clear with me that this is mental health, but he wants to continue and do some more work in substance abuse as well.

So just for whatever it's worth, I fairly consciously use mental health when I mean mental health, and I fairly consciously use either substance abuse or behavioral health when I mean both or just substance abuse. So those terms are important, at least in terms of you understanding how I'm using those words.

All right. So there's lots going on. It is an incredibly important time and lots of possibilities. The problem that SAMHSA has is we always have to figure out where to focus because there's so much coming at us, and sometimes -- and I acknowledge my own behavior about that -- we don't always focus enough.

But about the time we try to focus less, somebody pulls us in to focusing more. And it isn't always me that focuses more. It's sometimes other people that pulls us into that.

So, having said that, I want to just tell you the notes I took yesterday, because this goes into the council reflections about yesterday, I want to tell you what I heard about things that we as a council, and certainly as a set of advisory councils, might need to think about later. We're going to have another meeting in August. That's only about 4 months from now.

I think our April meeting got a little later than we normally like it to be because budgets and other things were going later than normal. I think we'd rather have that meeting more like in March, which would make more of a half year in between each.

But the next one is fairly close, and maybe that's not a bad thing. It's only about 4 months away, actually, from now. So August 14 to 16 is our tentative dates. Here are the things that folks told us about in no particular order yesterday.

The discussion about social impact bonds and business investing in social success. I thought that was an interesting comment and something I don't know if we want to have some more conversation about that. We could.

The whole issue of psychiatry, payment issues, the role of practice and practice

structures and how those may change came up in a variety of ways. We will have a new chief medical officer by August. So having her participate in that conversation with us is a possibility.

The other issue, and Fran, I'm recalling when we had some early conversation about prevention in the larger group. But frankly, we haven't done that for a year and a half or so, and there was a suggestion yesterday that we come back to the prevention issue. There are so many new council members, I think they may not -- everybody may not be on the page with where we have been working about prevention. So that was a possibility.

Organizational and system accountability in a time of transformation and change. So how we do -- Pete, this may be in your bailiwick, but how do we assure accountability and outcomes when organizations are just massively changing, whether it's States or providers or consumer groups or family groups or others? So that's an issue.

The one that got the most head nods and waves in the hand was SAMHSA enhancing its impact in a time of declining resources and how to do diffusion of innovation and the theory of change in a learning community, and a significant set of conversations or a conversation about reauthorization. What does that mean? If we were starting with a clean slate, what would we authorize a SAMHSA to look like and be like? What should SAMHSA look like in the future?

So that whole set of conversations it sounded like we really ought to think about taking on in some way. And it's good timing, and getting advice and input from others and from our advisers would be good.

And then the last issue I heard yesterday was evidence-based practice adoption. So out of that whole conversation about evidence-based practice and disparities was having evidence-based practices is one thing. Adopting them and actually getting them into practice is another. So that was another conversation.

Today, this group is going to hear about the latest on our Behavioral Health Quality Framework. I think we're very close to trying to put this out for another set of public comment, and we wanted to take it to you first. And then you're also going to hear a little bit more about the behavioral health workforce report that we sent to Congress. We are clearly thinking about what to do about workforce.

And let me just remind those of you who haven't been around with us for a couple of years. When we did the 8 strategic initiatives a couple of years ago, it started out as 10 strategic initiatives. We dropped a couple. One of which we dropped was workforce. Not because it wasn't important, but because we couldn't take on everything, and HRSA was doing a lot of work, and they have over the last couple of years really increased their efforts around mental health

and substance abuse workforce.

But nevertheless, workforce is back on our plates to think about what, if anything, should SAMHSA be doing about that? And then we're going to also have some updates on prescription drug abuse and the work that's going on there from Fran and Wes.

Agenda Item: Council Discussion – Reflections on Joint Council

All right. So that's what we're talking about today, and that's the topics from yesterday that I heard. So let me stop, let you all jump in, and see what you think about what you heard.

[Pause.]

MS. PAMELA S. HYDE: You can't tell me you didn't think last night. I know you all too well about that. Dee?

MS. DEE DAVIS ROTH: I was doing a complete brain dump on my poor husband last night at dinner, talking as fast as possible trying to explain to him everything that had happened in the meeting. And I had this odd thought that all of the national conversation stuff is so positive and so exciting, and the stuff about what may be in the law about people who can't buy guns has the seeds of possibility in it to rain on the other parade.

And so, if this will be big in the news and this will be big in the news, there's just a possibility that the two could conflict in a way that we wouldn't want.

MS. PAMELA S. HYDE: Good point. We worry about that. Got any advice on what to do about it?

MS. DEE DAVIS ROTH: No.

[Laughter.]

MS. PAMELA S. HYDE: Other comments from yesterday, this, about that or otherwise? Wes, how did your lunch meeting, and Paolo, go about that? Because I know that was the biggest group.

DR. H. WESTLEY CLARK: It went well. I think people wanted to be educated about the Brady bill and the amendments, and we also had some discussion about the proposed legislation.

I think by and large there was no disagreement about the importance of gun control. The issue that we were focusing on were the prohibitors, and so people were trying to balance these two themes, gun control on one hand and the importance of it, particularly as it impacts people with behavioral health problems, because suicide is an issue associated with access to guns. And we talked about that.

And then we had some free-flowing discussion. Clearly not wanting to stigmatize people with behavioral health issues in the service of a larger gun control policy, but at the same time endorsing gun control as a public health strategy that's necessary.

So we went through the details and went through the education. Paolo?

MR. PAOLO DEL VECCHIO: The only thing I'd add is we certainly heard the need for this policy to be evidence driven and data driven and the need really for us to help collect more data to support whatever policy change is to come.

MS. PAMELA S. HYDE: Did you get a chance to talk about the Department of Justice is the lead on this bill. But within HHS, Leon Rodriguez, who is head of the Office of Civil Rights, who works with us a lot on Olmstead issues and some other issues, and he's, I think, very well grounded in the values that we all would appreciate. But he also raised the issue that you did, Paolo, about evidence-based policy decisions.

So I know Paolo and Wes are meeting with Leon and a group of people, and we've proposed some researchers to think about what does the research tell us about who really shouldn't have guns and who -- it doesn't matter whether they do or not, they're not any worse than anybody else, if you want to think of it that way. So at least we're at the table about that.

DR. H. WESTLEY CLARK: We acknowledged that work and noted that we had just submitted to Leon a compendium of the research. And that compendium was put together between SAMHSA, CDC, and NIMH. Again, the issue, as Paolo points out, what does the evidence show, and are people even responsive to the evidence? So, and the fact that HHS is representing the public health paradigm rather than just being swept up in the cosmetics of the issue.

DR. MARLEEN WONG: I was impressed with that and the national dialogue and what was attempted, what was being attempted. And the thoughts I had had to do with the school shootings and the young people who seem to -- if we just look at that particular group and how they are very disconnected from any community. So here we have a community approach, and the transition age youth, many of whom are disconnected.

And it reminded me that I'm very much in favor of some sort of national service

for young people. Like all young people when they graduate have an opportunity, not that they're forced to do so, but to select -- to take some time and to have a national program where they can actually engage in some sort of -- some sort of initiative that gives back, builds communities, you know?

I have a son who spent, who lived in Israel and lived on a kibbutz. And I think that was a very life-changing experience that helped consolidate his values and a sense of direction. And I think that in our society, we seem to have that gap that for those who are ready to go through school, they do that. But there are just some that, and even those who are ready to go through school could really benefit from some sort of program that I think developmentally speaks to where they're at.

MS. PAMELA S. HYDE: That's a good point that I wanted to particularly reflect on the issue of isolation. We've thought a lot about that, I think Paolo and his staff, when they were helping to put together the constructs behind some of the proposals that are in the President's budget. This issue of isolated families, isolated youth, and how we need to make sure that doesn't happen, and that could be a contributing factor to whether it's mental health issues or a contributing factor even to violence issues. So I think that's critical.

Yes, Ben?

DR. BENJAMIN SPRINGGATE: Ben Springgate.

I wonder whether the compendium of research that's being worked on across these agencies -- CDC, SAMHSA, NIMH -- and I recognize that it's being developed in the context of the pending policy decisions and legislation that may develop. I wonder if that may be something that ultimately could be disseminated in some form more broadly.

Because communities such as ours that are very violent are struggling to figure out what they can do that is evidence based that might assist in tackling some of the gun violence issues that are faced across the country. And I know that some of the evidence base that you may be looking to may be specifically related to prohibitor lists. But there may be some other areas that are in the research that's being drawn together that may be relevant to communities.

And I know that SAMHSA has supported New Orleans in its efforts to try to get in front of this issue. But I can also point to the fact that we still have hundreds of shooting deaths each year. And even as we think about the comment that you just made, Marleen, and I agree with you about this opportunity for young people to elect service, just a week ago in New Orleans, a young man who just joined AmeriCorps from the Midwest was shot and killed at 11:00 at night, unfortunately.

So we're looking for evidence-based solutions, and we're trying to figure out how to address these things.

MS. PAMELA S. HYDE: That's a great point and a great idea. I'm thinking that the research we're compiling has less to do with solutions, unfortunately, at the moment and more to do with just what's the relationship between factors and gun violence or violence.

And I know one of the set of research that just came out very recently, like February, was a compilation of -- it was a book that just came out. A compilation of research, but it really -- I'm going to overstate this more simply than it really is. But those who have mental health issues and commit violent acts have sort of the same characteristics that those without mental health issues and commit violent acts.

It has a combination of poverty and location and opportunity and age in some cases. So it's not that much different, but to the extent that people with mental health problems are more likely to live in those neighborhoods or more likely to be poor or more likely to whatever, then the numbers may be more -- maybe higher among that group. So it was an interesting comment about just what are those factors.

Yes, Cassandra?

MS. CASSANDRA PRICE: Cassandra Price.

And one thing that struck me yesterday was the young lady that was sitting to my right. I think she was with the women's services group. I can't remember her name. But we were talking a lot about families.

And I think when we talk about transition age youth and we talk about opportunities and services and all those things, we forget that the families are typically struggling tremendously with what are the options? What are services? What are not even necessarily services, but what are community opportunities?

So like in Georgia, we have our Clubhouse programs, which are really recovery support programs. They're kind of like the old drop-in center mentality that aren't connected to a mental health clinic or a substance abuse center. It's really about engagement and having fun.

And we call it the bait-and-switch model. So we bait you in by letting you play games and shoot pool and have recreation. Good, clean, sober fun. But then we switch it up and go, well, let's go on and do some seven challenges or some groups.

And so, I think looking at things that are not necessarily just about clinical

models. So it's really about how you engage people and give people opportunities to do things that are missing in their life. And that population you're talking about around poverty and kind of being lost, not knowing if they're not -- maybe looking towards college is not an option for them. And the workforce is a challenge.

So what are those things that are missing in people's lives that make them struggle with depression or even crime? Where are those in-roads, and how do we support families to have options for those things and for youth to have other options, not just about mental health services? So I think there's a lot of things there from a social perspective that we can think about.

MS. PAMELA S. HYDE: Stephanie?

DR. STEPHANIE M. LE MELLE: I don't know if you're familiar with the work that Fred Osher is doing now. But there's this whole new sort of concept about criminogenic risk factors and exactly to the points that you were making, Pam, that even folks with mental illness and substance abuse, the folks that get themselves into trouble in terms of violent crimes and repetitive crimes have these criminogenic risk factors.

And we used to, from the psychiatric perspective, used to lump all of this into anti-social personality disorder, and that we'd throw up our hands and say, well, we can't treat that. We don't know how to deal with that. That's not something that we do. That's something that criminal justice needs to handle.

And now there is the sense that actually there are things that we can do and that if you look at the criminogenic risk factors, which are all the things that we know -- homelessness, trauma, family histories of violence -- that all of those things develop into what we've traditionally called anti-social behaviors. But that there are ways of addressing that.

And there are a couple -- I think there are two new papers that just recently came out about this. You guys are familiar? Okay. But it's really a different way of thinking about how do you intervene? What do you actually do? And it's not just that we throw up our hands, that we can actually address these things, particularly in young folks.

DR. H. WESTLEY CLARK: We've actually supported that work that Osher did, in conjunction with the Council of State Governments and Department of Justice. It's an expansion of not just the risk factors, but being able to -- factors are tied to the allocation of resources so that you can help prioritize which population gets which services.

The criminal justice system traditionally would give everybody the same vanilla intervention, which means those people who have high needs got the same

services as those people who had low needs. And that meant the low-need people got services they didn't need, and the high-need people didn't get services that they did need because those services were going to the low-risk people.

So it's not just identifying the risk factors, but also tailoring the intervention to be consistent with the services. So it's been reasonably well received by the corrections community, and the Department of Justice has promoted that they recently had a meeting where we just reviewed that -- when we could have meetings.

DR. STEPHANIE M. LE MELLE: If I could just add to that, though? I think the other important part, though, is not just for the corrections part of the community, but for the outpatient civilian part of the community. Because I think that mental health centers in general don't want people that have criminal justice backgrounds because they think that they don't know -- that they can't treat them. They think what are these folks doing in the mental health world or in the substance abuse world if they're bad people? We can't help them.

So I think it's important to promote it to the clinicians outside of the criminal justice system as well.

DR. H. WESTLEY CLARK: That's a good point.

MS. PAMELA S. HYDE: Marleen and then Dee. Some of this reminds me of some of the data that Ohio did years ago about the difference in levels of treatment. So you might reflect on that at some point. Yes?

DR. MARLEEN WONG: Well, Stephanie, your comments just lead me back to the importance of school mental health because I think that risk factors are not predictive factors because of protective factors, and that's what comes in early on. The opportunity for students to have some sort of service in early intervention in schools and not just by the time they get to the justice system, although in urban areas, they're already in the justice system, many of them.

MS. PAMELA S. HYDE: You know the comment you made is on some levels I think why the proposals that are in the President's budget are so focused on the under age 25 age group, both kids in school, what we can do about that, and then kids emerging out of school, whether they go on to community college or go on to college or go on to a job or go on to nothing, that that transition age is difficult.

And we sometimes get -- I sometimes -- I'll make that an "I" statement. Sometimes get pushback about why SAMHSA doesn't do more around the aging population, and there's no question. I mean, I am them. So there's no question we need that kind of intervention and assistance. But it's so clear to me that in a

tight budget timeframe and in a tight -- in the constraints of resources that the place we can do the most good overall, I think, is that under age 25 age group, where we can really do the prevention/early intervention efforts.

DR. PETER J. DELANY: I was going to note that one of the challenges that's coming out -- I mean, I love Fred Osher. I've followed his stuff for a long time. But one of the challenges, and this dates back to my time at NIDA, is the translation seems to go into we put it into minute categories because we have to sort people out, and the challenge is how do we maintain the idea of a person-centered approach?

And I think what Wes was getting at is we have high risk, we have low risk, and we try to develop something in the middle. And the real issue is a lot of these kind of categorizations create these kind of piles of services rather than say, okay, this person may need A, C, and D. This person, even in the same category, may need E, F, and G. And that's a challenge for everybody.

So not only helping the mental health community get more familiar and more comfortable with this, we really are in a challenge point where every one of the Federal agencies -- HHS is leading the way in terms of quality services -- are being thinking about patient-centered care. And this is across populations, the VA, criminal justice, mental health, et cetera.

But the field, and I think I'm part of that field, too, feels like, well, let's sort it in so we can't do it all. It's the chunking down versus the individual. So it is a real challenge in looking at the data that we don't end up just re-creating what we did after the war on poverty, which is just, okay, we'll just chunk it into this field, and we'll chunk it into that field. And people really get kind of the wrong services for that.

So that's just a thought.

MS. PAMELA S. HYDE: Okay. Are there other reactions to yesterday? I mean, we had lots of other topics besides -- this was one. But other topics? Yes, Chris?

MR. CHRISTOPHER R. WILKINS: Yes, thanks, Pam.

Chris Wilkins. I want to jump back to the social impact bonds. The indispensible elements, as I understand it, of that financing arrangement are the presence of a Government guarantor, the presence of a transformative practice, and an outcome-driven approach that will save a Government system or a social system money.

And the essential approach, as I understand it, is that a group of private investors, bond holders, sort of are committing to put risk capital or medium- or,

in some cases, high-risk risk capital out there at rates that are slightly under normal high-risk or medium-risk rates. Somewhere between 5 and 15 percent. The vehicle can sometimes involve the presence of a philanthropy that guarantees some rate of return to the investors if the Government entity will engage any guarantee of the principal.

The interesting -- you know, the interesting thrust of the vehicle is that it's a public-private partnership. It leverages private dollars. It gives Government entities -- usually in State and local cooperation, but I believe it bears examining whether it could be done in State and Federal cooperation -- it gives them a way to enhance and leverage greater dollars than they would have, for example, in a targeted capacity expansion grant.

If the outcomes are achieved and the Government saves money, the return is returned to the debt holders. That's essentially it. I think that there is crossover interest between -- crossovers in interest between the stimulative innovation effect that SAMHSA has always had and the purposes of those financing vehicles. I believe that that potentiality of unity of interest is enough that it bears examining by the agency, Pam, to see if there is a viable partnership.

The sense that I heard from the initial Goldman package was that we think this can be done State and local, and that was the arrangement, in fact, in the New York City School District. But we don't think the Feds could ever move fast enough or flexibly enough.

I tend to believe the opposite. I believe that healthcare reform especially is about being fast and flexible, or at least that intent is there. And that we should create some sort of vehicle to examine the potential of the social impact bond financing vehicle and how it may or may not complement the stimulative innovative work SAMHSA is doing.

MS. PAMELA S. HYDE: That was a very helpful probably to everyone explanation of sort of the process. I have been around the edges of some of those processes at a city level, particularly in Seattle, where the city business community was very interested in investment in schools and was doing some public-private partnership kind of in the way you're talking about. But I've never been in and around it at a higher-level government.

And my experience is the higher the level of government, the more difficult it is to get things to happen quickly. On the other hand, doesn't mean it can't. Because I have seen things happen in the Federal Government in 4 days sometimes when it's really desired. Although that is not usual, I will say.

So I guess the thing I would put back to both you, Chris, and the rest of the folks is we really do have to always think tough, make tough choices when a neat new idea like this comes forward about what staff, what resources, what energy

would this divert from to take on even exploring something like that? And it's not a small thing anymore.

I mean, we are all up to our eyeballs in things we're already committed to. We don't have resources to bring on a lot of new people. We don't have resources to put out new grants. We used to be able to do a few things a little bit around the edges that was easy to get someone to do a little piece of work on. That's less possible.

So I say that back to you only to say is it enough of a new and creative idea that we really should divert some staff from doing something else in order to explore that? And what do you all think about that?

DR. STEPHANIE M. LE MELLE: There might be -- it might be worth looking at some of the smaller projects in New York, where this has actually worked. I'm thinking of there are a few housing programs that have actually done this, where they have sort of -- they've taken investment money with HUD money and developed these supported housing programs that are mixed-use supported housing programs.

And I mean, just looking at how they set it up and how easily it was done might give us an idea of whether it's worth the investment.

MR. CHRISTOPHER R. WILKINS: Chris Wilkins again.

Those are tax credit deals, and they're actually in Federal legislation. So there is 7 percent and 9 percent tax credit deals, and that's how they leverage the housing money. It's a similar vehicle, actually. But there's in Federal and State statute a tax credit vehicle to do that.

I think also, Pam, that we can -- there may be ways to develop more information on this to bring to your attention before you make the decision of committing resources. There is enough motivated folks out there with this idea right now. We can sort of push them in your direction to do a coherent briefing, and then you could sort of have a full set of data before making a decision about whether this is worth agency effort.

MS. PAMELA S. HYDE: Thanks, Chris. It sounds like you've got some background. We may call on you. We do, from time to time, call on people individually to help us think through some things. So, thanks.

Okay. Other comments either about that or go on to some of the other topics? Yes, Megan?

MS. MEGAN GREGORY: Well, I just wanted to touch on reaching out and engaging more youth. I know there is a presidential youth campaign that's

happening right now. I believe my two Senators, Senator Murkowski and Senator Begich, along with Senator Udall, Senator Moran -- I can't remember the fifth person -- are supporting this campaign.

And I think I know that Dorothy Stoneman, who is the CEO and founder of YouthBuild USA, who created the National Council of Young Leaders, wanted to make this happen with our council. But she didn't want to wait for the Republicans and the Democrats to get together and figure it out.

MS. PAMELA S. HYDE: Yes, that might take a while.

MS. MEGAN GREGORY: So she started her own through YouthBuild USA, and I'm really looking forward to going back and advocating for what SAMHSA is doing and figuring out what it is we can do to help promote what you're trying to accomplish.

I'm also excited for this Presidential Youth Council, and I think that it would be fantastic to get one of their young people onboard with what we're doing and have them help us promote what SAMHSA is trying to work on. So I hope that's something that we'll consider as this council is forming.

MS. PAMELA S. HYDE: Great. Thank you.

I think some of those -- there clearly is an interest in having youth be part of the national dialogue launch and effort across the country. So building on those opportunities would be really helpful.

Okay, and we do have a few minutes on the agenda a little bit later to talk specifically about the national dialogue and what you all might think we should be doing about that.

Are there other comments about yesterday? Again, there's the psychiatry payment, role of practice structures issue. There's the prevention issue, the organization and system accountability issue, the SAMHSA's future, what should it look like, reauthorization issue, and the evidence-based practice adoption issue that still we haven't really talked about.

MS. ELIZABETH A. PATTULLO: This is Betsy Pattullo.

I had a couple of observations. One was I was a little embarrassed that Pam had to remind us of what the Accountable Care Act has in store for us come January 1st, but I found that very, very helpful yesterday to realize that this speeding train really is coming along and that at least in the legislation there are some dramatic improvements in terms of the integration of access roads for people to open the doors to the 62 million people who will become eligible for insurance.

And I take that back as a helpful reminder. I actually thought the discussion about evidence-based practice and disparities and, in a sense, the tension or lack of tension between what we know intuitively works in our communities versus what the evidence shows works was useful.

Somebody made a comment at one point about how estrogen used to be very popular and no longer is. As a non-academician, I'm a little skeptical about some of the value, or value isn't the right word. But the extent to which we rely upon the evidence because in my, you know, 61 years, the evidence tends to change over time. And I think finding the balance between what we believe in fact is effective, whether it's in a particular community or in our general experience, and what we have learned through the science is something that we need to continue to struggle with as a community to make sure that we take the best advantage of it.

I also -- I just would like to say that I think Marleen's comment about national youth service is something that's very interesting to me. As we've watched 12 years of war without a draft and 1 percent of our population taking part in it, from the very early days, I wondered, as the mother of two sons, if we had a draft if we would have decided to go in as vigorously as we did.

And the absence of a place that brings people from across the country from different backgrounds, from different experiences together in a consistent way, I think has been kind of a failing in our country. So I think that's something to really think carefully about.

And then, finally, just Ben's comment about the tragedy recently in New Orleans and the level of gun violence. I think it's worth taking a look at what works. You know, in New York City, the trend has been down pretty dramatically in terms of gun violence. In Boston, the trend has been down. There are some States, including Georgia and Texas and others, that are doing some interesting things in terms of reinvestment of criminal justice dollars in community settings.

And I think in L.A., historically, when we had terrible, terrible gang problems, there were some community interventions that were really pretty effective, and I'm not up to date on where that stands. But I think paying attention to some of the things that when we get activated as a community, which tend to involve what Megan was talking about, connecting young people in ways that historically maybe haven't been so effective and empowering them can make a real difference.

So I found the discussions to be very stimulating, and I look forward to more.

MS. PAMELA S. HYDE: Ben, just on that last point, because I know the New Orleans mayor and Karen DeSalvo and folks there have really looked at some of

what other cities and other States have done. Do you have enough of that information off the top of your head to comment?

DR. BENJAMIN SPRINGGATE: The mayor and the health commissioner and others are drawing on the ceasefire model, based out of Chicago and other places, to see whether -- and trying to target specific neighborhoods with some sort of peace navigators, community -- graduates of the youth in the community who are trying to deescalate violence in the ceasefire model as it's been applied elsewhere.

There's a program or a campaign called Flip the Script that has engaged some national celebrities as well to try to draw attention to it. To instead of focusing on the tragedies that befall youth, instead draw attention to the opportunities and the fact that there are kids graduating and emphasize some of the positives that are occurring in communities as well.

And so, there are efforts that are being undertaken. There are efforts being undertaken in criminal justice and in mental health services delivery, that reform and improvement. So certainly those things are underway and not insignificant, but the violence continues, unfortunately.

MS. PAMELA S. HYDE: Your last comment, and Fran, you may want to say something about this. But I was struck not this year, but I think a year or 2 ago at CADCA when the young people from that conference got up and said, gave us all a bunch of numbers to react to, and none of us knew the numbers because they were all the positive numbers. And everybody in the room knew all the negative numbers, but none of us knew the positive numbers.

And the kids, the young people were saying this is how many of us graduate. This is how many of us go to college. This is how many of us don't take drugs. This is how many of us. So your comment is well taken.

I don't know, Charlie and Megan, if you have a response to that, too, because we do tend to look at the number of people who is you people and the number of people who do bad things, and we don't tend to look at the positives.

MS. MEGAN GREGORY: I completely agree. Senator Byron Dorgan always says bad news gets around the world before good news has a chance to get its shoes on. So I think it's very important that we highlight the good that's happening and the good numbers and just shine light on what we can do to continue encouraging youth to live positive, happy, healthy lives.

MS. FRANCES M. HARDING: Yes, speaking of evidence-based programs. It's been proven in higher education prevention that sending out the realistic and good news, it's sort of a balance. Let young people on campus know how much alcohol and drugs are being taken and who's taking them is a far smaller number

than what the perception is of most college students. And that helps.

Bringing the numbers -- I spoke to a couple of the students that Pam is talking about from CADCA, and they were very proud. And they said, though, it was very difficult for them to get the numbers. That it was much, it's not as easy to find out how many people have actually gone to college and graduated, how many people belong to youth groups, than it is to find out how many young people were arrested or died or et cetera.

So between that and the fact that Megan and I are going to link up after this to talk about the President's Youth Council and see if SAMHSA can do anything to help you. It's a good idea.

The last thing I'll say is evidence-based practices, perhaps if we do focus on a little bit on prevention, my recommendation is to focus on the evidence-based practice rollout of prevention. I think you'll find it very interesting to see how it not only is paralleling what you heard yesterday with disparities in evidence based, but for 25 years prevention has been working on this.

So I think it would show a nice balance of some of the successes and some of the disadvantages of relying too much on evidence based, which was also brought up yesterday.

DR. STEPHANIE M. LE MELLE: Stephanie Le Melle.

In terms of we sort of spoke yesterday about how we develop evidence-based practices and whether they're useful or not, but we didn't really talk about the clinical use of evidence-based practices, which is a real problem. And I think part of it, and I don't remember who mentioned this yesterday. But in the training programs that we have, and maybe we'll talk about this when we talk about workforce development, I think if you go around to residency training programs in the United States and ask them how many of them are actually teaching evidence-based practices, particularly those that are designed for people with severe mental illness and substance abuse, they're not.

I mean, they don't teach it. Or they'll give a lecture on it, and that's it. There's no real implementation of evidence-based practices in the training programs. And one of the things that we might consider is really pushing the accreditation organizations to really require, whether it's through licensing or through accreditation of training programs or all of the sort of national organizations, to really make it a requirement that they train people with the evidence-based practices.

It's the best thing that we have, and it's not being taught. And so, if it's not being taught, it's certainly not going to be used. So we can have all the best evidence practices in the world, but if we're not using it, it's kind of pointless.

MS. PAMELA S. HYDE: You know, I have a primary care doc in Santa Fe. That's where I keep my healthcare at a women's health service. So it's a nonprofit. But it's a practice of women and men physicians and practitioners, and they have a mental health person onboard, and they have other kinds of folks.

But anyway, my primary care doc is not fresh out of school, but she's a lot younger than I am. And it's really interesting because they've gone to electronic health records. But beyond that, she tells me now because she knows the work I'm in, and she tells me that like every Monday morning or every other Monday morning, whatever it is, they actually have a quick and dirty roundup of the staff, and they go through whatever the latest research is or any kind of things coming from the Federal Government and the Federal care act about incentive dollars or whatever.

So they really are trying to, as a practice, like every other week go through what's the latest information. And this came up because she asked me about my smoking at one point, which I don't smoke. But she asked me about it, and I said, "Well, why are you asking me that all of a sudden?" as opposed to why didn't she ask me how much I drink? I mean, we literally are having these conversations.

And so, she's telling me about how they're paying attention to what the either the research or the incentives are suggesting they do. Now that's, I think, a fairly unusual practice that every other week they're literally having somebody responsible for saying in a really short like 30-minute staff meeting, "Here is what we know is coming out. Here is what you should be asking your clients or your patients." So --

DR. STEPHANIE M. LE MELLE: That doesn't routinely happen in most clinical settings.

MS. PAMELA S. HYDE: I know, but this --

DR. STEPHANIE M. LE MELLE: Particularly in mental health settings. I mean, maybe in some really progressive family practice or specialty programs, and this sounds like this is a real unique specialty program. But what the public has access to and that most insurances are paying for or Medicaid dollars are paying for, you're not getting that.

But I mean, I think it's doable. I mean, having that type of a review on a regular basis and just say, just exposing people. In our training program, I just asked folks if they knew what the golden eight evidence-based practices were for people with severe mental illness, and they couldn't name them.

MS. PAMELA S. HYDE: Yes.

DR. STEPHANIE M. LE MELLE: So, I mean, that's a sad state of affairs, and this is at a major academic institution where we're teaching it. But this was when they were coming in. They hadn't heard about this.

MS. PAMELA S. HYDE: Well, and I think the thing that was particularly compelling to me about that is we talk about evidence-based practices all the time, and we don't that I'm aware of in behavioral health -- and that means both mental health and substance abuse -- have routine ways in which we say here's what it is today. It's going to change tomorrow. We don't have the sense of a fluidity of evidence.

I mean, we're still trying to get people to do evidence-based practices that were dealt with 20 years ago. And frankly, some of those practices grew up in the context of a particular type of payment system. So, in fact, Paolo and I have had brief passing comments about sort of one of our golden childs about systems of care for kids, for kids with high-risk needs, really grew up in a system where kids were getting access to coverage in some places, and they weren't getting access to talking across systems.

That's changing just by the way the coverage system is changing. So it behooves us to ask, well, the systems of care need to change now based on that. So, but we're still 20 years later trying to get what we think of as the evidence-based, and it still is, but my point is that it's got to move and change.

So other hands I saw over here. Pete? Remember to say who you are. I'm not good about that. I should say it myself. Sorry.

DR. PETER J. DELANY: Pete Delany, Center for Behavioral Health Statistics and Quality.

Actually, I can echo what you guys are talking about. Every time I go to Bethesda to get my healthcare, I get -- it doesn't matter where I go. I go to get my blood draw, they say, "Do you smoke? Do you drink? How much? Are you feeling sad? Are you feeling suicidal?" So I'm saying, "For a blood draw?" But whatever.

So the last time I did my physical, which is several places around, every single place asked it. And I gave them the same answer each place, and I said, "Are you guys double checking with each other? I just wanted to know." That was the EHR that Wes and I are working on.

But I do want to get into -- and this gets into this accountability issue for the organizations. And I'm going to give another military example. I used to do my clinical practice at Bethesda and from like 1999 to when I took this job, and I saw

increasingly, obviously, a lot of PTSD cases. And we were all trained very well, but there was no supervision for it.

So we got back to it, and it was like there was nobody there to supervise. So we can -- it's not the accreditation that I'm scared of, although that's helpful. I'm scared that we're not -- we don't pay for people to be supervised. We don't support supervision.

And I think this has got -- it's got something we have to think about as a field is how do we ensure that all the support systems -- I've been trained in about 18 different evidence-based practices over my career. Not one of them was supported when I went back. Usually I got back, "Well, you had your training. Get back to work."

So dissemination is not so much getting people trained because we have the evidence in our little computers upstairs that says there are certain things that show when people use evidence-based practice. But we don't show anything about what support structures, and that's something we're trying to fix now. That's one of those little models you're making me build.

I'm going to get a big bunch of Legos for you, Pam. I'm not kidding. So that's --

MS. PAMELA S. HYDE: There are new evidence-based Legos, I have to tell you.

DR. PETER J. DELANY: Yes, it's called Minecraft, and I can give you the URL for it because it's all gone Web.

So I think is as we go, because social worker is my profession. And social work rules are requiring training as part of training through your social work program. However, nobody in the field is training supervisors on how to do it. So that's a challenge.

MS. PAMELA S. HYDE: That's a good point. Yes, Chris?

DR. STEPHANIE M. LE MELLE: Well, no, I'm glad you raised that, Peter. Because one of the things that --

MS. PAMELA S. HYDE: This is Stephanie.

DR. STEPHANIE M. LE MELLE: I'm sorry. This is Stephanie Le Melle.

You know, one of the things that we've started doing in our training programs and in the consultation studies that we're doing in New York City with the other training programs is specifically on supervision. And when you talk to clinicians about what is the role of the supervisor, people have never been taught how to

be a good supervisor.

So one of the things that we've started doing -- or how to use supervision, right. So one of the things that we've started doing is incorporating that in our consultation studies where we actually do in-service trainings with the supervisors as well as sort of working with the trainees. And it's a really important thing.

But the data that we're getting in doing this, the pushback is that people don't have time. That there's no built-in time in the clinical systems that we work in to actually do supervision because if you're doing 15-minute med checks and 20-minute therapy sessions, when are you going to be able to sit down with your supervisor and talk about it?

So I think having that protected time set aside as part of the system of care is really, really important to ensure that.

MR. CHRISTOPHER R. WILKINS: Chris Wilkins. This will actually follow on Stephanie's comment.

At every stage of my career when we've billed a Medicaid rate, we billed Medicaid rates with personnel -- personal services and capital components, and those capital components usually touch the bricks and mortar in the institution. It is absolutely apparent, as I commented yesterday and as this conversation begs, that the compliance, quality assurance, supervision costs have to be understood as a component of the delivery cost, and they've got to be thought about.

MS. PAMELA S. HYDE: Okay. So we're kind of in a weaving in and out of some of these issues. There are still a couple we haven't touched on. One of which is the organizational and system accountability in a time of transformation and change. And one is the SAMHSA's future and what should it look like in the future and its reauthorization, and if you could draw it on a page with a blank page, what would it look like?

Do you have any comments about any one of the two of those issues? Part of what I'm trying to get here at is what -- there's always interesting issues to discuss. That's not hard. The issue is what that I try to use you all as advisers about is from what came up yesterday, what do we need to put on our next agenda for the whole group so that we use their time, use your time well and for things that we really need the input about?

So all of this is hugely interesting. We've just got to figure out which ones are most. So what about those two comments or those two issues? Anything from that that raises interest for you?

MR. CHRISTOPHER R. WILKINS: I just want to jump in on the SAMHSA in

2015 and beyond issue, Pam.

All of the words in the mission and vision statement focus on the end state of the consumer, or most of the words. I shouldn't say all. Recovery is possible. The treatment is effective. Life in the community for everyone. And that's an end state that is inspiring, and it drives our focus.

The other part of the conversation that I think needs the articulation is a little bit of Archimedes, right? Give me a lever and a fulcrum, a lever long enough and a fulcrum, and I'll move the world.

SAMHSA, it would be interesting to define SAMHSA as a fulcrum, right? What are the inputs from SAMHSA that drive the end state that's envisioned in the vision and the mission? And defining those inputs as transformative practice stimulator, as forum where policy and regulation and financing and consumer interest all come together to drive refinements of those areas so that there is synchronicity and unity of purpose in supporting the end state.

In other words, can we look at the voice of the consumer and the financing and the policy and the regulation dimensions nationally and at the State and local levels and normalize all those questions to the end State that the agency envisions, right? And then, within the limited resources that you have, to prioritize those things that are possible and attainable, right, and to reach them.

So I'm urging the conversation shift focus a bit, acknowledge that the end state is what every question must lead to and every dialogue must lead to, but what are the priority inputs that have to exist to get there? That's the framework that occurred to me somewhere between 1:00 and 2:00 this morning.

MS. CASSANDRA PRICE: Hi. This is Cassandra Price.

Definitely will not give my opinion as eloquently as Chris does. You're such an orator. I'm just impressed with your verbiage.

But I think to kind of build on the inputs and outputs discussion, I think it really is critical to figure out from a 2015 and beyond perspective where the other agencies intersect here. Where are the boundaries between SAMHSA and CMS and other funding agencies and policy-setting agencies, and how do they intersect, and what are the roles and boundaries of each?

Because I think we can't look at just SAMHSA and figure out where you're going to be without looking at the entire infrastructure around healthcare. So I think that's a critical component, and maybe there's even opportunities for joint strategic. I know that's a novel idea, but some joint strategic planning between some of those critical agencies about how their roles delineate.

MS. PAMELA S. HYDE: ELT members, does any of this raise anything for you?

MS. FRANCES M. HARDING: I just want to put a plug you should talk about the Behavioral Health Coordinating Committee.

DR. H. WESTLEY CLARK: Yes, I was going to mention the same thing, that, in fact, we are attempting to do that, and it's not just the Behavioral Health Coordinating Committee. There are all these subgroups that we're all working on that are communicating almost on a weekly basis on this or that.

So under Pam's leadership, we are, in fact, trying to get a handle on how behavioral health is and health, how health is being mediated by the Federal Government, and CMS is now much more available in terms of collaboration. I can remember the previous administration we couldn't get the time of day, and now we've gone from that end of the spectrum to the other end.

MS. PAMELA S. HYDE: I agree with Cassandra, Chris. You're being quite elegant. And Cassandra, your point about relationships with other entities, I think we're really worked hard to have those relationships, which isn't to say we couldn't do more. We can.

But some of what you said I think is what we've been struggling with as an ELT, and that stands for executive leadership team. It's the four center directors, the four office directors, and a few other folks around the edges that are important like Kana and myself and Mirtha and others. But anyway, that group has been spending significant time in the last 3 or 4 months trying to look at what I think is what you said, Chris, although, again, you said it much more elegantly. But just trying to look at what are the things that we need to be focusing, on the way we've framed it is to SAMHSA leads public health efforts to advance the behavioral health of the Nation.

So that's different than our mission and vision statement. We're not changing the mission and vision statement, but trying to say what should SAMHSA be in that context? And then what are the fulcrum, the whatever you want to call it. But, and policy is part of it and what are some of the other things?

And influence, Cassandra. We've been thinking more about how do we use our efforts to influence people who are making decisions that are going to have a major impact? I mean, we are just not the main payer. We just aren't.

We're closer to a big payer in the substance abuse side, but we're still not. And as the next 62 million people come on with some substance abuse in there, we're not going to be the biggest payer. And so, how do we stop worrying about paying and start worrying more about influence, push, policy, and how do we use the payments that we do make, whether it's grants or whether it's block grants or whatever, to really try to move things?

So it's moving the world with that fulcrum. So I like those images. That's good.

So the question is, on that one I think, is how and what's the best way for our advisers to be in that for us and with us? Is it an open-ended discussion? Is it a panel? Is it to tell you what we've been thinking about and have people react? I mean, what would you suggest about that?

And the context for this for us has been forget reauthorization. Just given what we've got and the constraints in front of us and all that, what will we do? There is a time where we're going to have to cross the bridge, and we've gotten right to the bridge a few times and said, nah, not today. For lots of reasons.

But we are going to have to look at reauthorization, and reauthorization has, as I said yesterday, been stopped a couple times because of a political issue that has to do with terrible choice and the politics around that.

But setting that aside, if we were to reauthorize today, we might or might not reauthorize in ways that the statutes say today. And that's a big congressional issue because Congress may or may not agree with us or may or may not be on the same page with us about that.

So that's a lot to say what would be the best way to engage advisers in that conversation in your view?

DR. STEPHANIE M. LE MELLE: Stephanie Le Melle.

I think getting a sense from you guys because, obviously, I think there's a lot of stuff that happens that we don't hear about. But getting a sense from you guys what you're capable of doing and what you've been thinking about doing. Because I think -- you know, my idea of SAMHSA is that SAMHSA can do everything. But obviously, SAMHSA can't.

And as I've worked with SAMHSA, I've learned more about what you guys are actually able to do, and I think that given that sort of more realistic view, I'm sure you have ideas of what you think would help. And I think for me at least, knowing what you're thinking about would help me to sort of more strategically think about which way to push you.

The one plug I would make again is about the data and mining the data and really trying to organize. I know. There's going to be money passing back and forth here.

[Laughter.]

DR. STEPHANIE M. LE MELLE: But I just -- it's so important to have an

organization that has the same values that we have, the clinicians have, and that you guys are the ones producing the data and that it's not coming from pharma, and it's not coming from other agencies. But it's coming from our mothership would really be helpful.

DR. PETER J. DELANY: Here's that ship metaphor. I thought we were off the ship metaphor.

MS. PAMELA S. HYDE: Our regional administrators now call us the mothership.

DR. PETER J. DELANY: Oh, okay.

MS. PAMELA S. HYDE: I don't know if they're referring to Anne or if they're referring to -- Anne Herron is back in the back here.

DR. PETER J. DELANY: Lately, we've been talking a lot about cars. So maybe we should just --

MS. PAMELA S. HYDE: We were talking about rocketships at one point. We have different analogies.

DR. PETER J. DELANY: We should just stop metaphors for a while. Okay. So this is the challenge Pam gives me about every 3 minutes. But that's part of why CBHSQ now exists is to do that, and we are expanding fairly rapidly, including one of the things Pam and I actually totally are in total synch about is that we need to do a lot more with financing.

But we're not only going to mine more of what we gather, but we're going to mine more of what other people are gathering. We're working on creating an internal data enclave. We're working on gathering strength, and the people we're hiring are multifaceted. They're not just survey statisticians. We are not your -- we're not OAS anymore.

We are a full-fledged center. We're hiring analysts, evaluators. We're working with the centers pretty interactively on new evaluation strategies so that we have evaluations that we want to publish our successes. We're working with OC, especially Marla, to figure out how do we create visibility about what we already know?

And the other thing that I'm like stoked about, but also just kind of racking my brains, and this is what keeps me up every night, is not only I figured out, I think, how to get these new data systems here. We're not going to own them, but we're going to go mine them. We're working with AHRQ a lot. We're working with CDC. We're working -- now we're looking. We have a multipayer claims database that Westley hooked us into. We're doing some very innovative things that are going to take a little while because we're just learning how to play.

The thing that I'm really excited about is how are we going to make a data savvy workforce here at SAMHSA so that they -- that we become, everybody becomes a resource for their grantees, for the field that we teach each other. There's a lot of practice wisdom in our centers that they're teaching us as we interact. And the challenge is then, okay, so if we create a new measure, how do we actually measure it?

And you say that's really important, then we have to work with you to figure out how to measure it, or we have to figure out is that one we want to spend a lot of time on? So there's a lot happening here. The challenge is, is right now is not only going there, but prioritizing.

Our key issues right now, to be honest with you, are really trying to look at the fact that we're going to have 11 million people hit Medicaid and Medicare. How do we gather data from the HIEs, and Wes and I are constantly talking about EHRs, what measures are going to go in. How do we do all this and prioritize what we're going to try to -- and then what are we going to try to put out?

We put out tons of data literally daily here. And I'm not sure, I mean, I was really challenged by the idea. How do we publish the census? We can tell you how many people are having problems. But we also conversely can flip that around and say, you know, we got like 21 million people who aren't -- who have problems that aren't necessarily getting treatment, but we've got a lot of people who have gotten treatment. So now I've got to figure out, hit priority number 7, how do we publish what our successes are in different ways? And that's really going to be a challenge for us.

MS. PAMELA S. HYDE: Okay. So this is exciting. Cassandra and then Dee.

MS. CASSANDRA PRICE: Cassandra Price.

I love data. It's always a fun time. But I sometimes come back to a real simple thing, and it may be off kilter. But are people getting better? Are they moving towards recovery? And that's what we sometimes always talk about like treatment episodes and how long someone was there and what the short-term outcomes were.

And so, I'm always thinking about that. Did people get better, and did they move to a place of self-defined recovery? And if they didn't, then that's where I think you have the cross reference of different payer sources and different systems. So even if we're not the main payer. So if they're not getting better, then what is missing?

Is it the quality of care that they're receiving? Are there certain services that aren't covered? What is the gap there that's not moving someone to recovery?

And that's, to me, a critical juncture where I see SAMHSA as kind of the recovery capital of the world of how do we intersect in there to ensure that people get from the clinical to the recovery.

So that's just again simplistic, but sometimes we focus on all the other details, and that's something I always worry about we're missing.

MS. PAMELA S. HYDE: Cassandra, your point is well taken. It kind of goes back to the evidence-based prevention issue, which is we're sort of starting to try to take a look at what do we know about our prevention efforts? And if we know that in the place where we give a grant, X, Y, and Z happens? And maybe it changes by 20 percent. But then across the country, it's not changing at all.

So does that simply mean we need more grants, or does that mean 20 percent isn't enough, or does that mean we haven't strategically chosen where we're going to put those grants in order to make the difference that's going to make the country change? I mean, what does that mean?

So we are trying to use data in a little different way to be kind of a learning community. But that, again, this is a shift in the way SAMHSA thinks about even its data for itself.

All right. Dee, I'm going to take --

MR. PAOLO DEL VECCHIO: Can I comment?

MS. PAMELA S. HYDE: Yes.

MR. PAOLO DEL VECCHIO: On Cassandra's point. I'm Paolo del Vecchio. Thank you, Fran.

We're working with Pete on developing a recovery measure right now. So we're in this year hoping to test that measure, and we'd love to chat with you more about that in ways that, again, Pete's point how we can use this to then look at the other measures and what's missing ultimately in helping people live happy, fully lives.

MS. PAMELA S. HYDE: I think part of what you're seeing here, I hope, also as well is that each one of these individuals at the other end of the table here, the center directors, they all have a responsibility for their center. But we've asked each one of them to take some leadership across the organization about a particular thing.

So whether it's prevention, it's not just substance abuse prevention. Fran manages and leads the prevention efforts across the agency, and Paolo leads the recovery issues across the agency, and et cetera. So there's some cross-

fertilization of our expertise as well.

So one or two more comments, and then we're going to go to a break. Yes?

MS. DEE DAVIS ROTH: I'm Dee Roth.

A while ago when we started this discussion, you rattled off very quickly a phrase that you said you were thinking about it internally. It started out "SAMHSA leads public health to," which struck me as a really good kind of a framing thing. But you said it too fast, and so see if you can dredge that back up again.

MS. PAMELA S. HYDE: Anybody want to say it down there? We've been living and breathing this phrase for a while.

MR. PAOLO DEL VECCHIO: SAMHSA leads public health efforts to advance the behavioral health of the Nation.

MS. PAMELA S. HYDE: And you can imagine every word we have teased apart. What does "leads" mean? What does "public health" mean? What does "the Nation" mean? So we have gone --

MS. DEE DAVIS ROTH: Well, it really struck me the minute I heard it that it was a great phrase. It was just I didn't -- it was too fast.

MS. PAMELA S. HYDE: Okay. Great. Marleen and Chris, and then we'll take a break here.

DR. MARLEEN WONG: Well, I think SAMHSA has accomplished a lot. So 3,000 miles away, I'm a PI for one of the National Traumatic Stress Network grants. We're Category 2. And I've been in the network since 2002.

So we looked at our population in Los Angeles, did some research with our colleagues at Rand. Found that in South L.A. and East L.A. that over 90 percent of the children had been at sixth grade, 11 years old, exposed to violence in over 90 percent. Twenty-seven percent of the students had full-on PTSD sitting in their regular classrooms. Sixteen percent had depression.

Created an evidence-based practice. It's in NREPP. But the good news to me about what happened is that we're moving away from the intervention. Like we have our data about it's effective. It's been replicated across the country. But to me, the good news is that we've moved away towards prevention, and that's where I think SAMHSA has been so successful.

And the success story is that, okay, we were in the schools. Our social workers were in the schools implementing this intervention, and the teachers got onto it. And they said, wait a minute, we've got kids we know are coming in and they're

traumatized. And we can't teach them in the morning because they are just so disruptive, picking fights. It takes 40 of the 50 minutes to get them calmed down so that we can finally start teaching.

Two of those teachers decided we need to have a trauma-informed school, their idea. They created a trauma-informed high school so that all the teachers would be on the same page about understanding how kids who live in a neighborhood that has high rates of poverty, high rates of crime can take a look at kids' behavior and say, "What's going on?" And build into the school ways to prevent them from getting thrown out and keeping them in.

To me, that's a SAMHSA success story because it's sort of like the end result of the trauma grants. And it's a public health approach.

MS. PAMELA S. HYDE: It's a perfect example, and I think, to bring it all the way back to what we might talk about with our advisers is we are very much beyond understanding that our only resource is a dollar. Because we have more dollars, less dollars, more grants, less grants, different kinds of grants, whatever. Those things are definitely a resource we have to use in a specific way, and we try to be very strategic about that.

But Paolo's time is a resource. My head time is a resource. The amount of time Kana and Daryl and others have to talk about 16 different budgets in a year is a resource. Fran's ability to go out and train somebody is a resource. So there's only so much of that.

Marla's time in getting communications out the door, the statisticians and others, and how many pieces of data can we put out and which ones are strategic is a resource. I mean, you can go down the list. So we've tried, I think, to be more -- and even our advisers and what we can get you to do for us and think for us and what we can suck out of you when you are here is a resource. And all of that is finite. There is only so much of it.

So I'm always amused in some ways when people say things like, "Well, this wouldn't cost anything." Well, it does. It costs my time. It costs Kana's time. It costs the centers' time. It costs our time at trying to advocate with the White House or with the Secretary or whoever has to make a decision or CMS. It's a lot of time.

So we're trying to be more thoughtful about that. So, hopefully, this stimulates you a little bit, and we're a little behind here. But I think this was an important way that I use you to just help us reflect on how might we set up the next conversation to be really helpful. And I think this one about SAMHSA's role is something again we've been spending tons of time on. So your input to that, I think, will be very helpful as we proceed on this.

All right. So we are a little past time. We were going to take a break at 10:15 a.m. We will take a break. And we've already had a little conversation about the national dialogue so we may run into that just a tad. But let's take a break maybe for 10 minutes. So start again at 20 till by this clock over here, if that's okay?

[Break.]

Agenda Item: Consideration of Minutes from the August 2012 SAMHSA NAC Meeting

MS. PAMELA S. HYDE: All right. So we've got a quorum back at the table. I forgot to do the minutes. So I need to let you know and let everybody know that the minutes were sent to you in writing. So you should have had a chance to review them.

I will first take a motion to approve them, and then we will take changes.

MS. ELIZABETH A. PATTULLO: So moved.

MS. PAMELA S. HYDE: Is there a second?

DR. BENJAMIN SPRINGGATE: Second.

MS. PAMELA S. HYDE: Okay. I understand there is some conversation about this. So, Dee?

MS. DEE DAVIS ROTH: Dee Roth. I have a small correction to the minutes. It's small, but important. It's on the bottom. The minutes are in the Tab 2, and it's at the bottom of page 4.

What it says, it's like three lines up from the bottom, "She noted that consumers consider measures of symptoms and stress to be important." That should be "measures of symptom distress" because consumers, in fact, thought simple measures of their ongoing symptoms were not important, but rather what was important was how much distress those symptoms were giving them. And that's a different issue.

MS. PAMELA S. HYDE: Thank you, Dee. First for reading them and, secondly, for catching the error.

All right. Anybody else have any comments about the minutes?

[No response.]

MS. PAMELA S. HYDE: All right. Hearing none, do I hear any disagreement with the minutes?

[No response.]

MS. PAMELA S. HYDE: Okay. So moved then. I mean so accepted.

I just want to make sure. Is Lorrie Rickman Jones on the phone? Okay. She was going to join us if she could. So, all right. So I'm going to turn this over to Pete and Lisa.

Pete Delany is head of our Center for Behavioral Health Statistics and Quality. And Lisa Patton, I have no idea what her technical title is, but she is quality person number one managing our National Behavioral Health Quality Framework issues. So, Pete and Lisa?

Agenda Item: National Behavioral Health Quality Framework and Barometer

DR. PETER J. DELANY: She actually wants to be called "Empress."

[Laughter.]

DR. PETER J. DELANY: Okay. Sorry. Anyway, yes, Lisa is our Acting Branch Chief for the Evaluation and Quality Performance Branch. We actually, we're trying to make acronyms that don't work on purpose.

I want to do a real quick framework for you. One of the challenges and opportunities that Pam has given myself as well as my colleagues in ELT is to build a world-class center for data, and there's a lot of things going on. I talked a little bit about what we're doing there. But I want to give you a framework because really we're talking about measures. We're focusing on measures today.

The first thing is the quality framework, as you know, builds on the National Quality Strategy. But at the same time, we're working on creating a number of different products for the agency, as well as for the world.

We're also looking at developing -- Pam also challenged me to get the measures into manageable chunks. So Lisa has been adding an effort on creating what we're calling the core measures so that we can get measures down to what core treatment, what core mental health, what core prevention, what core infrastructure. So we're doing the rule of six because my knowledge is if you get

six, you're going to get eight or you're going to get four. It doesn't matter. So we're going for the rule of six.

Then we're also -- so there are some additional measures that we use as the supplemental measures. But we're trying to get to the point where we reduce burden on both our grantees, but on the field as well as create high-quality measures that we're targeting now because the reality is as we move forward, and this is going to happen across HHS, some measures are going to be really important now. But as we get traction in them, we're going to move to other measures.

And the idea is to not just keep adding measures, to say let's retire that and work on something else. So the idea is to keep this is a living kind of approach rather than let's just make a document that's 56 pages long that we do not want to do a tax code here.

So let me kind of quickly just reframe for you and talk about two of our really key projects in this. The first one is the National Behavioral Health Quality Framework, which is, as you know, the NQS strategy focuses on better care, healthy people and healthy communities, and affordable or accessible. We added the word "accessible" care because "affordable" is there, or actually, it's "accessible," and we added "affordable" because sometimes the two don't meet.

There are six goals in here, and I'm going to do this is if you want to stop me for a question, just raise your hand and I'll stop. But the six goals are evidence-based and effective; person, family centered; coordinated within behavioral health; between behavioral health and other care.

So, again, those are two key issues. One is the behavioral health field is not coordinated with each other, and we're not coordinated as well as need to be with other healthcare settings. And I mean beyond primary care. There are other healthcare issues. And to promote healthy living and to be safe; and then again, accessible and affordable. So those are our goals.

Now here's the challenge that we're looking at, and I think part of this gets at this issue of accountability. We're looking at payer, or public basically, and the private. Who are the people that are paying, public and private? But essentially, stuff that directly influences that. Those are the measures that you can directly influence what's happening.

And then the provider practitioner, and that's really where we're thinking about accountability. What kind of provider practitioner measures, where we don't have direct influence, but we're asking questions -- and this is the challenge that Pam is really giving me. Even if we don't have a measure, let's ask the question somehow so that we say, okay, this is an empty space, but we're going to figure it out and force people to begin thinking about it.

Because that's part of our job is even if we don't have a good measure yet, can we say that's an area you've got to pay attention to?

And then the other one, which I think OAS, and when I first came in, that's what we were really comfortable is population. We got the population data. But that's still important, and that provides a context for understanding.

So also we had a criteria for how we're working. The measures need to be endorsed by NQF, National Quality Forum, thank you. And the idea is we don't a lot of the States and localities are having to implement these through their CMS work. So we don't want to make them add a whole bunch of other things. Again, let's get measures that work, but let's make sure we don't create new burdens.

They have to be relevant to NQS, the National Quality Strategy priorities. They have to address high-impact health conditions, and we want to promote alignment with the program attributes across programs and including the health and social programs and across HHS. Just that fourth one alone is create -- I had brown hair and a lot more of it before I started. That fourth one alone is creating some challenges, but it's really some interesting opportunities.

Then we want to reflect the mix of measurements -- outcome, process, cost appropriateness, and structure. We've got a lot of process measures. That's where we're good at. We're not real good at outcome yet. We're getting there, although I don't think the health field is as far ahead as they may say they are, too.

And we don't have as well in terms of structure. And we have to be able to apply across episodes of care. We have to be -- if we're going to actually have an understanding that this is a chronic set of conditions that have to be addressed over time, we need to move beyond the acute methods.

And then, finally, we have to account for disparities. We're doing better. We're getting there, but we need to keep building there.

So I'm going to let Lisa take over here to talk about some of the measures that are in there, and we're getting ready to -- I did send this out to people and the council. We got some feedback. The next step after we have a discussion here is for Pam and us to work together to figure out, to get it out and let the public take potshots at it and get people to say, "Here is what's working. Here is what doesn't work."

DR. LISA PATTON: Provide constructive feedback.

DR. PETER J. DELANY: Yes, potshots.

[Laughter.]

DR. PETER J. DELANY: Sorry. Too much talk of gun violence today. But to let the public have access to this information because a lot of them are doing some really cool stuff, and we want to get that information because we don't have all the little nooks and crannies going.

So, Lisa?

DR. LISA PATTON: And actually, the Behavioral Health Quality Framework, it provides us an opportunity to help shape how behavioral health activities get measured across HHS. And so, we've partnered very closely with HRSA and AHRQ and other Federal agencies to take a look at the measures we're including in the framework.

As part of that, what we did is we had an internal HHS panel nominate measures to be included in the National Quality Framework to get at the population level, provider and clinician, and payer level measures that we should be looking at. And so, what we did then is after having that, engaging that internal HHS group -- and I should say all of our Federal partners are doing this kind of really tough examination of measures that get at what they need to, but again, we're really hoping to shape where we go with behavioral health.

We extended the review to a large external set of stakeholders, about 30 people -- researchers, clinicians, consumers -- a broad variety nominated by you all as well as internal to SAMHSA and HHS. And so, we had a lot of feedback during that process and completed that about the end of December.

And what we did then is take a look at the measures that were nominated across both processes and pulled from those to identify the measures that people were really saying captured the kinds of things we need to be getting at. And as Pete mentioned, we're really looking for a core set of measures.

What you'll see in the final version of the framework is a core set of measures that we think get at key issues, but supplemental measures as well that can get at some specific vulnerable populations. We've heard concern about rural health versus urban and telehealth issues, those kinds of things. Where we can't capture those now in the core measures, they will be addressed in the supplemental.

And as Pete also mentioned, we're hoping to really drive the field in a number of ways. And we'll be reviewing these measures on a routine basis to retire measures when they have been fully implemented and we don't have to worry about those kinds of measures anymore, and we can look to other gaps areas or places where we really want to try to push for better care.

So in terms of evidence-based practices, what you see before you are a number of the measures that people felt were very important to push at this point. Looking at major depressive disorder and suicide risk assessment, looking at depression utilization and remission rates, looking at engagement -- initiation and engagement of alcohol or other things, drug dependence treatment, maternal depression screening. I mentioned we are partnering with HRSA, and that's an area they're very interested in, and it affects a lot of the consumers that participate in SAMHSA programs as well.

And risky behavior assessment. And we had to make a decision because there are excellent measures for getting at this in adolescents, and there's a recommendation to screen by age 13 or by age 18. And we decided to go with 13 to really get at early intervention and really get in there as early as possible with these types of screenings.

MS. CASSANDRA PRICE: Can I ask a quick question? This is Cassandra Price.

DR. LISA PATTON: Yes.

MS. CASSANDRA PRICE: So when you talk about the goal being evidence-based practice, what specific EBP -- I can't even talk straight -- are you looking at around initiation and engagement of alcohol and other drug dependence? I guess I'm trying to link the goal to is it SBIRT or is it --

DR. LISA PATTON: It is. It is, yes. It's an SBIRT measure that's actually in the NQF pipeline.

MS. CASSANDRA PRICE: Okay. Okay.

DR. LISA PATTON: Yes, and so for the purposes of the presentation today, I didn't link it with the NQF. But I can share all of that.

MS. CASSANDRA PRICE: Great. Thank you.

MS. PAMELA S. HYDE: Just remind you, this is a little hard to see in this way, but it gets complicated very fast is, as Pete said, there's three different contexts. One is the provider context. I mean, I'm going to say this wrong.

One is the payer context. One is the provider or program context. And one is the population context. So there might be a measure in each of those for each of these or not, depends on the situation.

DR. PETER J. DELANY: We can send out the supplemental big, quartile tables for people to see.

DR. LISA PATTON: So goal two gets at person-centered care, and we all agree on the critical importance of measuring that really well, but we also know it can be very tough to get at. I just attended the NQF annual meeting and heard from virtually every speaker about how across healthcare people are really trying to capture the consumer evaluation of care in a number of ways and get at that in a very meaningful way so it can affect positive outcomes as well as enhanced treatment.

And so, we identified this as a tough area at this point for us to get at. And so, as the description there shares, we highlight it as key to quality care, but we're also saying we need more work in this area. So this is an area we're very supportive of in terms of measure development, and there are a number of strong measures, we hope, in the pipeline to get at these issues better. But we welcome feedback on that as well.

So goal three, coordinated care. A number of the measures that we're hoping to get to or that we're prioritizing at this point, medication reconciliation, post discharge, timely transmission of transition record. So really getting that material shared across providers or agencies very quickly. And follow-up after hospitalization for mental illness. So we're looking at that and looking at a number of timeframes for that, as well as follow-up after hospitalization for substance abuse.

MS. CASSANDRA PRICE: That's exactly what I was about to ask.

DR. LISA PATTON: I beat you to the punch, Cassandra. I saw your finger on the buzzer.

Physical health, comorbidities for special populations, there's been a lot of very strong work done with schizophrenia and bipolar conditions around this. We're seeking to expand that work and to get into same chart-based measures looking at BMI, a range of different issues that -- smoking cessation -- that are of importance to our population.

And I left HIT for last. We are really hoping to get to an ability to use health IT to perform care management at the point of care and track that.

MS. CASSANDRA PRICE: Lisa, can I -- this is Cassandra Price -- ask you just a quick question for clarification? So when you use the term "hospitalization for mental illness" and when you're talking about even broader for substance abuse, are you talking about psychiatric hospitalization at a certain level? Are we talking about crisis stabilization units and detox?

I think clarity around defining hospitalization from State hospital versus community-based hospitalization is very critical.

DR. LISA PATTON: Absolutely. And the measures that we have are very clear on that.

MS. CASSANDRA PRICE: Gotcha.

DR. LISA PATTON: Yes, and we can share those. But I will point out there are also measures in the pipeline to look at follow-up after ER visits. Yes, so really getting at it in a number of ways.

Healthy living for communities, goal four. Again, we look at smoking cessation, the risky behavior assessment as an indicator of a community functioning well. Really addressing adolescent health issues at a young age. Again, we chose 13 instead of 18. And the assessment of comorbid health conditions such as smoking, obesity, and blood pressure.

And what I will share with you all is that this one has really been identified as the goal that poses the greatest measurement challenges at this time for many reasons. But across the board we've heard from people and doing a deep dive into the literature and here at SAMHSA talking with our colleagues, there is a lot of difficulty in getting some strong community-level health indicators that will work for our purposes. But we are thinking about that very carefully. Please?

MS. PAMELA S. HYDE: Lisa? I'm sorry. Go ahead, Charlie.

MR. CHARLES OLSON: This is Charlie Olson.

Are you familiar with the ACES study, the adverse?

DR. LISA PATTON: Yes. Yes, thanks.

MR. CHARLES OLSON: I would encourage you to look at that. There's a lot of --

DR. LISA PATTON: Yes, thank you.

MS. PAMELA S. HYDE: I should know the answer to this, but I don't. A lot of times we talk about age 12 because of where our data starts. A lot of time we talk about age 14 because of where the IOM leaves off. Why 13 as opposed to 12?

DR. LISA PATTON: It's the way the measure is constructed. Yes, because when we -- because the measure, for whatever reason, the measure is constructed to assess risk at 13 or at 18. By 13 or by 18. So I'll have to go back to the actual measure because --

MS. PAMELA S. HYDE: So why did whoever created the measure and NQF, if

they endorsed it, why did they pick that cutoff? Did they have a scientific reason for that?

DR. LISA PATTON: I'll have to go back to it and pull that. Yes.

MS. PAMELA S. HYDE: It's just interesting.

DR. PETER J. DELANY: I can tell you that we spent -- when I was on the panel, we spent a gazillion hours talking about these ages. And I can't even quote the number of studies. And it was kind of like come to a consensus that this is the best one we can pick right now.

MS. PAMELA S. HYDE: Okay. And when it says "by age 13," it means literally 12 years, 364 days?

DR. LISA PATTON: You got it. Yes, very specifically. Yes. Yes.

DR. STEPHANIE M. LE MELLE: I just had a quick question going back to the coordination of care. On the follow-up after hospitalization for mental illness, are you tracking initial intakes, therapy intakes, and mediation management? Are you able to split that out?

DR. LISA PATTON: Those would be separate. Yes, it would be separate measures.

DR. STEPHANIE M. LE MELLE: But you're tracking all of those?

DR. PETER J. DELANY: Well, again, we're putting the framework out. So we have to separate. Remember, there's stuff that SAMHSA is going to track in its grants and requirements. There's stuff that we're encouraging the field. So we're trying to drive the field to do it. So that would be that payer/provider, and then there's the population level. And at some of those, we're going to be able to get it. Some of them we don't have ways to get it at the population level so we're developing it.

But you have to -- again, you have to think about payer, which is what SAMHSA does and what we're asking other providers to do, provider level, which is more we're asking the organizations and programs to start doing that, and so we're trying to drive the field. It's not just what SAMHSA is going to track, but the whole field to go in that direction.

MS. PAMELA S. HYDE: Whoever is on the phone, can you all mute your lines? We're getting a little bit of feedback. Thank you.

DR. LISA PATTON: Goal five is to reduce adverse care events. And so, the measures that rose to the top with our discussions about this measure, this goal

were patients being discharged on multiple antipsychotic medications. Again, coming back to the major depressive disorders and making sure there's been a suicide risk assessment, that that's documented. And then child and adolescent major depressive disorder, including a suicide risk assessment for that population as well.

And the last goal, goal six, reduce the cost of behavioral health care. And so, the measures that we identified as getting at this issue at this point in time are rehospitalizations within 30 days of discharge from in-patient psychiatric care, rehospitalizations for medical conditions, and then follow-up after hospitalization for substance use disorder.

And the caveat that we present there is that tracking and measuring cost is an area that requires a lot of work, as I'm sure everyone agrees. And we also are very sensitive to the impact of healthcare reform and how that's going to shift cost and what we want to look at. And so, we're very much invested in exploring how that changes and where the gaps remain.

MS. CASSANDRA PRICE: Can you talk a little bit more about, my mind is swimming, about the reduced adverse care events? And I guess I keep thinking in my head an adverse care event also would be not being coordinated and having follow-up potentially. So I'm just trying to kind of wrap my head -- I've never seen that one before, or I forgot about it. I was just trying to wrap my head around it a little bit.

DR. LISA PATTON: And you're actually -- I mean, that's a great point, Cassandra, because it's mirroring the discussion that the group had because we can look at adverse care in behavioral health in a variety of ways. And poor care coordination can certainly result in that, yes. So that would be something we could consider as including as a core measure or as a supplemental.

MS. PAMELA S. HYDE: I would think of this, Cassandra, as the coordination of care as a process measure or process set of issues, and the adverse care is actually an event or -- I mean, I don't know if that's totally true to where you've been at, but that's how I would think of the difference.

MR. CHRISTOPHER R. WILKINS: Chris Wilkins.

Lisa and Pete, why not rehospitalization after discharge from an in-patient detox within 30 days?

DR. LISA PATTON: These are examples. Yes, I apologize. This is not an exhaustive set of the measures that we're including. This was just to be -- yes, just a quick snapshot of them, yes. It's in there. Yes.

DR. PETER J. DELANY: One of the big challenges in all of this, again, is we

need to get down to some core measures, like two or three per cell, to start with. The supplemental measures, we're saying these are also really good measures. The challenge is if we go with everything, this will be a book bigger than the -- seriously will be very large. We won't be able to give you enough pages for your binders.

So the real challenge, and I again would encourage you to take a look at these, and we'll send out a whole package. Maybe email because it's pretty -- it's pretty big.

Let's take a look at we're trying to really come down to what are the two or three measures in each cell that are going to help us right now and move us along? It doesn't mean the others aren't important, but quite frankly, our grantees in the field are already balking. You should see U.S. -- the Prevention Task Force and the family physicians are pushing back very hard what CMS is asking them to do.

So, and I am aware that Pam warned me of this is when we put out the measures, everybody is going to come back, "Great measure, but I have better measures." So everybody has a measure for a problem. So our challenge here and our ask of you is to take another look at this and say here we are. Where are we? Are we in the right place? If we're not, help us understand what will get us to the right place.

But I have to tell you I can't thank not only Lisa, but her whole staff and everybody that's working with us, and the whole center and the whole agency has been involved in this and all our colleagues. This has been a really, really interesting approach because we have CMS playing with this. We have AHRQ. We have HRSA. We have everybody trying to do the right thing.

And I have never seen it align in my 21 years in the Federal Government. I've never seen people trying to align things as well as we have in the last at least a year and a half.

MS. CASSANDRA PRICE: This is Cassandra Price.

I mean, I will say, Pete, you know, we're picking at them a little bit. But I do -- your point is well taken that it is so critical to really focus on the key measures and really hone in because States do not have the ability to do 50,000 new measures or to try to change their systems and then drill down at the provider level.

So I think you're being conservative and trying to really drill down is very important to States and providers. So just as we pick at you, we do recognize the importance of that and appreciate SAMHSA and that consideration because sometimes that is hard for States to adapt. So --

DR. PETER J. DELANY: Well, we welcome the constructive criticism. I mean, that's the only way we're going to get there. If there are other questions, don't wake up in the middle of the night? Don't think you can't come back and talk to us. We are on the Web.

Let me move on to another component of what we're doing with the quality, and that's the National Behavioral Health Barometer. We started this out with just using SAMHSA data, and Pam has really challenged us to move beyond because what we're trying to build is SAMHSA as kind of an information network for the behavioral health field. And that means not just our data. We talked about this this morning. We really are accessing more data.

And at this point, the barometer has expanded to a whole lot of measures more than is useful. So we've added in data from BRFSS. We've added in data from Medical Expenditure Panel Survey, although we haven't figured --

I'm sorry. Behavioral Risk Factor Surveillance Survey, which is kind of repetitious. And Monitoring the Future also from the healthcare utilization panel survey, and we're -- we just -- we downloaded the Medicaid and Medicare, and we actually figured out how to use that dataset. I'm like stoked for that one.

I'm not going to pass it out because we're now up to like I think we're up to 40 measures in there as of today. We've got to hone it down before I send it to you. But we want to talk a little bit about the idea here is to provide a state of the Nation and a state of the State because we can do it at State and national level. We cannot do it at local. We can't do that yet. That's our goal.

So these are key indications of SAMHSA population as well as other population data. Our treatment facility and HHS key datasets as well as we're also looking at buying some private. Bob Stephenson from CSAP has identified some private insurance companies that will be willing to let us use their deidentified data systems so we're looking at that.

And we're looking at point in time that reflects a current status as well as being able to do trends over time. So, yes?

DR. BENJAMIN SPRINGGATE: Ben Springgate.

I'm impressed with the barometer concept and what you're putting into it. Obviously, I know you're about to explain more.

One of the things, as we were talking about the goals and some of the sample measures of the goal, that occurred to me that also seems to fit in with this barometer notion is that probably we're going to have a very difficult time capturing any information about the care or health of those people who are entering prison, which is a lot of our relevant population and in many

communities is the largest mental health and default mental health and substance use provider and patient set.

So it seems to me it's going to be difficult. The goals and measures, as are spelled out, are going to be probably targeting a lot of the data that's available in the context of care processes that involve traditional systems and reimbursement-based systems and things like that, which won't get to that population or that setting probably unless -- and I don't know the answer to this -- there is something happening in the context of the ACA that is going to enable people to carry their coverage into those systems and somehow enable tracking based on the fact that now everyone, presumably 97 percent of people or more may actually have some coverage that may enable some type of tracking to occur.

But I just wanted to point out specifically for the barometer perhaps, I'm wondering is there any way to think about or is there an opportunity to get insight into what's happening in the behavioral health and the services delivery in those settings?

DR. PETER J. DELANY: It's a real challenge. We'll have to think about that. I do know our colleagues over at DOJ, especially in Bureau of Justice -- in the Bureau of Justice Statistics -- say that three times fast -- do collect a lot of that data. So it would be interesting, although not as much in terms of the behavioral health and health. We have better information on the Federal side because they're mandated.

But it's an interesting challenge to see how we can incorporate that. And as you see, the bigger challenge is how do we paint a context without saying -- putting something in that says this, but we can't contextualize it for everybody.

So let me say, all to be said, more to do on that. We're aware of it. We do, actually, and we'll have to look at the systems, we do collect a great bit of data about criminal justice involvement, and that may be in the community level. So that may be where we're going to have the most bang.

Prisons and jails, we lose track of people because we are legally mandated not to go there because there are three major data systems going on in sort of this kind of level data. One is the community, which is mandated to SAMHSA. The other is prisons and jails, which is mandated to DOJ. And the other is in the military, which is mandated to DoD.

We have in VA -- we have -- just recently, I met with the head at USUHS, VA, and DoD data systems 2 weeks ago, entered into an agreement that we're going to figure out an MOU. So we have a verbal agreement to do an MOU to figure out how we play together.

What I'm -- and Rob Lira, who we just picked up, who is a stellar epidemiologist, is going to be liaison with them to help us bring that. My next goals is to start to figure out who do we kind of integrate with VA. I'm sorry, the DOJ in a different way. But right now, I'm kind of focusing on the VA and the military because we have them in our datasets now. We just haven't been able to identify them as well.

So we're looking at that. But it's all to be said, it's a good question. We'll look at it, and I'll get back to you on that.

DR. LISA PATTON: And I'll just add, too, that SAMHSA has representation on the AHRQ quality workgroup, which has DOJ representation as well. So DOJ and DoD, and so those conversations are happening at that level as well. And then ASPE is looking at that continuing coverage issue, along with CMS. So, yes.

DR. PETER J. DELANY: Again, when I --

MS. PAMELA S. HYDE: Just a quick comment. It's Medicaid right at the moment that precludes coverage while you're in prison or jail. That's not the case if you have Blue Cross Blue Shield or employer coverage or a lot of the other expansion that will occur under the Affordable Care Act.

Now how that translates to data or how that translates to payment for treatment is another matter. But there is a distinction there, and to the extent that the expansion is not just in Medicaid but is in qualified health plans, there's no reason that should go away when someone goes into a prison or jail setting.

DR. BENJAMIN SPRINGGATE: Yes, I agree, assuming that someone in the prison or jail system or justice system is going to utilize the BCBS or for --

MS. PAMELA S. HYDE: That may be true. But this is where we have to challenge ourselves to think differently about the future, which is if you think about the number of people who are very low income -- homeless, whatever -- very low income, who end up in jail primarily, frankly, because they haven't had access to treatment, the more they become covered and get access to treatment, I think actually the jail demographics may change over time.

So I mean, and I don't know what will happen with that. But it's kind of mind boggling to think about what all the implications could be over time. So anyway, without that digression, go on.

DR. PETER J. DELANY: The real challenge here is, again, one of the things that we're building right now is the economic analytic unit. And we're hiring and also building the services research unit. So our goal is to have these young people, mostly because some of the older people like me don't get it. Okay --

MS. PAMELA S. HYDE: That means Pete and I.

DR. PETER J. DELANY: Mature. Maybe we should just use "mature." Anyway, yes. I'm not going there. My daughter already thinks I'm too old to actually get new stuff.

But we're really looking at building new models to project so that the other potential is to gather some of these other datasets and kind of create some projections.

Beth Han and Mira Ali, Beth is one of our analysts in the NSDUH team, and Mira is our brand-new health economist. They're doing this projection on of the 62 million people, we expect 11 million people were going to be coming into the rolls for behavioral health services. So that's one projection, and now we'll be able to do some new projections based on that.

And Richard Frank has been stellar at helping us think outside our regular boxes. So all be said, more to come.

So some -- so, in this, we're going to examine some prevalence and treatment data for youth, adults, and older adults using NSDUH MEPS Medicare data. For example, percentage of persons age 12 or older with alcohol dependence or abuse in the past year by race and ethnicity. This is one of the things that Arturo challenged me. Can we break it down?

We can't get it too far because at some points we get to cells with like not enough people to actually make sense. But every one of these will have some kind of a breakdown. We're used to this kind of stuff. Percentage of persons 18 and older who have serious thoughts of suicide. Those are the things you're used to us doing.

It doesn't want to go anywhere.

MS. PAMELA S. HYDE: Just go slow, Pete. You have to push it and then kind of wait.

[Pause.]

DR. PETER J. DELANY: Well, let me -- I can go on without it. Charlie can fix everything.

MS. PAMELA S. HYDE: We're going to typecast our young people here to be able to do this stuff, and you may or may not care about it.

DR. PETER J. DELANY: We also are able to look at persons 18 or older with

serious mental illness, number of persons enrolled in substance use treatment, and single day counts of people getting methadone treatment.

Also percentage of fee-for-service Medicaid enrollees for all ages using A and B services for behavioral health treatment. Percentage of people 12 to 20 who are binge alcohol users, although I think we're leaning toward looking more at heavy alcohol use than just binge use.

And then the percentage of -- so some of the similar things. Percentage of those who used illicit drugs in the past month. Again, we're looking at new ways to kind of cut and slice and dice. Part of the whole goal of this is, is not just to present the data like here's the State. But we're hoping that States will start using this as well as to start thinking about, okay, in my State, here's my big issue. And then we will track with them how they're doing on that.

And the hope is we'll be using this as part of the block grant later as we revolve it. So, and then, again, we see these measures as the cool thing about this is the Web document. It's not pen and paper. It's a Web document. So as we learn more about how to use the data, we'll be posting new pieces of data. And as things change, we can also remove document pieces.

The other issue is as we're working in the -- with the block grant application is not only is this available to them, but they can add their own data, and then we're going to take that data because we're working right now to identify State-level data that they're using, and we're going to put it into their State application when we get it ready.

Yes?

MR. CHARLES OLSON: This is Charlie. Just to satisfy my own curiosity and probably some OCD, what's the reasoning between having 12 to 20, 12 to 17? I'm seeing a lot of different age ranges.

DR. PETER J. DELANY: Sure. Okay. So these are some relatively regular issues for SAMHSA. First of all, our NSDUH data, where we have it, goes down to age 12, although we're now developing a new thing where we're going to be working with parents to gather data below 12. We can't ask kids below 12. No IRB review board will allow us to, but we will get the data. But 12 is the lowest range we have right now.

Twelve to 20 is the underage drinking issue. So that's a break there. But also we find that 12 to 17 is a good break for understanding age groups in terms of there really are some different groups, and our standard groups are 12 to 17, so pretty much high schoolers; 18 to 25, which are college as well as the people that go into the workforce; and then 26 to I think we usually keep around 44. But we have some breaks there. And then now 50 and older because we're now

doing the baby boomers as a separate issue.

So those are kind of how we break it up based on the kind of real categories. That's consistent with pretty much everybody in HHS.

MS. PAMELA S. HYDE: It is confusing. The 13-14 was confusing, but at some point, we have to go up to age 18 because that's the adult versus nonadult population or youth versus adult. But then the underage drinking, it's beyond adults. I mean, in all States I guess at this point, underage drinking is under 21. So that's why you get that overlap in the 18- to 20-year-olds.

MR. CHARLES OLSON: I figured that it was the cutoff on 20 because of the age to drink. But I was like it's 20 years old, it's still illegal for illicit drugs. But I didn't know that there was different age groups going on.

DR. PETER J. DELANY: It's really a way of kind of chunking. Because we have everybody, and then we kind of compare the groups. But it also helps when you think about it where you're going to target certain levels of intervention because certain interventions for, say, the 50-year-old is not going to work on a 12-year-old.

So it also helps you think about what are the patterns of problems among those different groups to think about in terms of developing treatment interventions, prevention interventions, recovery services. They're somewhat different. So that helps. But we can talk about that more if you'd like.

MS. PAMELA S. HYDE: Okay. We got about 10 more minutes just for the presentation and the discussion. So we need to kind of move on.

MS. CASSANDRA PRICE: Cassandra Price.

I think it's quick. I get the barometer. I get we're trying to get a pulse on what's happening in behavioral health from some of those basic key indicators.

For the National Behavioral Health Quality Framework, how do you see that being implemented to States from like a grantee or an accountability standpoint? How do you see that kind of going from the State level to the provider level, and how does that feed into kind of like what we currently do around TEDS reporting and different datasets?

I'm trying to figure out what the pathway is. I get the barometer, but I'm trying to figure out how you envision this thing implemented, and you may not have the answer to that question yet. But --

DR. PETER J. DELANY: I think we're creating -- well, this is part of the process that Lisa and I are trying to develop now. We're trying to harmonize -- we've

already -- I think we've done a pretty good job of harmonizing with the NQS, but we're also tweaking it.

All right. So let's set barometer aside for a second. Barometer really is our ability to give States a picture. But the framework moving out, again remember, the purpose of this is to help change the field's way of doing business. So, with that, the idea is that for one thing, on that payer grant, that's some of the stuff we're going to ask our grantees to give us, and we're going to ask other payers to start doing it. And we're already having a tremendous amount of impact because we work very closely with Suzanne Fields about how do we move CMS a little bit. So the payers are starting to get it.

And then in the provider level, you'll see we not only have that provider level, but also we collect other data in our NSATs and in TEDS, although TEDS really come from a different group. And then in the population, that's really where a lot of the barometer and the other issues are going.

We also are creating this core set of measures in treatment and prevention and infrastructure. Those are going to be harmonized with the quality.

The idea is that we don't keep -- again, as we kind of keep a limit, I think what we're looking at is the evolution of what we're doing in terms of collecting client-level data. And one of the things that we're moving toward is we're really beginning to enter into some discussions with NASMHPD and NASADAD to really kind of coordinate all of these efforts to come up with things that, A, make -- what are the key things we want to strive for, but also make sure that these measures make sense for the coming few years and that everybody is onboard.

Everybody is going to collect a little extra data, but if we get down to some core things that everybody agrees on, wow, we can change things. Because right now, we have a history of everybody collects their own data. So SAMHSA, the mission that Pam has charged me with and I'm moving forward is to help create a real behavioral health information network, and SAMHSA can help coordinate it.

We're not going to do it all, but we're going to help push people to think about how they can do it together.

MS. CASSANDRA PRICE: Thank you.

DR. PETER J. DELANY: You're welcome.

Last slide maybe. Okay. So, today, you have the history of this. We started this in August of 2011. We went to the councils again in '12, lot of leadership optives, everything. I mean, down to the -- let's focus on fall and winter, we had the outside. Lisa talked about it.

So we're at spring. We've got a revised document that we sent out to the council. We've got comments back. At this point, we're going to be working on it again. We'll send it out, and if anybody has anymore comments, we'll do it. We're getting ready to put it up on the Web and have public comment on this and try to work with this. And I'm envisioning a process similar to the recovery measure -- or the recovery definition and the trauma work.

And then we're going to then, hopefully, by end of summer 2013, that's this year at least, put this out and publish it, and that's a working document. And then there will be Version 1.0. So we're not -- again, this is a living document. We're going to, hopefully, retire measures as we make traction, add new measures as real issues come up, and be able to work for it.

So that's where we are. Really simple stuff, and it doesn't keep us up at night. It keeps us up all day. So that's where we are.

MS. PAMELA S. HYDE: Yes, Betsy?

MS. ELIZABETH A. PATTULLO: I'd just like to say, as somebody who is kind of skeptical about this stuff, I think it's fantastic. And the direction that you've gone, I was on the call as an observer in August, and I was terrified about, you know, the direction that this was going in. But I think it's very, very promising, and God bless you for doing all the work.

MS. PAMELA S. HYDE: Well, we thought we could do it in 2 or 3 months, and here it is 2 years later. We're still trying to get it, the first one cooked, but we're getting there.

So comments, reaction? Dee, especially I know we had you and Arturo responding 6 months ago or so, whenever it was. Any comments about what you've seen progress?

MS. DEE DAVIS ROTH: Yes, I guess I've seen this three times now. So I'm more at the minutiae than the overall. I think it has progressed. It has gotten -- each iteration has gotten more sensible and more coherent.

And I think that a little bit of the reaction that you're hearing today is what the reaction of anybody is going to be. It's complicated. So people are going to go to page 8 and see this one thing that freaks them out. So you're going to have to kind of go in and back out and in and back out with people trying to explain this because it is a document that most people -- I mean, I'm familiar with this kind of stuff. It's a document that most people aren't familiar with looking at and trying to understand.

So I think that a little of that help in understanding it is going to be necessary.

MS. PAMELA S. HYDE: Here is the other challenge that I'm already going to throw out to Pete is the barometer is really becoming sort of a state of the Nation, if you will, about behavioral health. It's not a report of the National Behavioral Health Quality Framework. Because a lot of the measures, we don't have any way to capture whether people are doing them or not.

So we can say here are 10 things you all should be measuring, but we don't really have a way for most of them, maybe for some we do have some pieces. But we don't really have a way to sort of create a report that says here's how the Nation is doing on these measures. So that's the next challenge, Pete. But that's for later.

But we do need to make sure that people don't see these as the same thing because they're a different thing. I wouldn't want you to get comfortable, Pete.

DR. PETER J. DELANY: That has not happened in 3 1/2 years yet.

DR. STEPHANIE M. LE MELLE: Stephanie Le Melle.

I think this is really terrific. And in thinking about what SAMHSA can do in the future, this is just so important because we don't have -- we, the clinicians, don't have a database that we can go to that has this kind of information. So I think it's terrific.

But as I'm thinking about it, the other next step, I guess, is how are you going to present this? How is this huge thing going to be useful, you know? And I'm just thinking about how let's say I wanted to look up my State data on a particular thing. Like how would I navigate this?

So I'm sure you have a lot of folks thinking about how this is actually going to be put on the Web and how it's going to be navigating -- how you'll navigate it, depending on whether you're -- which stakeholder perspective you're coming from and how you would get to all that.

DR. PETER J. DELANY: That's my 3:00 a.m. thought process. No, actually, again, this is something we have been thinking very diligently on. We're looking to build, like we have the treatment locator. We're actually looking to build on the success of that to create very user-friendly -- you know Kids Count in the Kaiser stats where you just click on your State, up it comes? That's where we're going with this.

So here's your state of your State, and here's all of your information about your treatment data. My goal is to get to the point where we also go here is your data on your quality measures for the State. And so, I have one place where -- one-stop shop where people can pull it up, but really user interface.

The other thing that we've done is we've created accessible, very easy to access datasets, like we have restricted datasets online with formats so that you can pull down. We also have the SAMHDA, which were the data archive, that you can run just basic statistics. You can sort it by State. You can sort it by things. We're looking to make that more visible, but we're also increasingly put up easy-to-use tables that people can just go, "Here is where we are."

So I just heard Pam say my next step is a report card, which will just make everybody happy because when I say, "Here is how your State is doing." So at that point, I'm just going to put Pam's name on it. The principal signed. I'm just the guy. But I think we're really moving toward report card kind of reporting, and Lisa and I will be thinking about that with our colleagues.

MS. PAMELA S. HYDE: Well, on the barometer, you're going to have some State-level data in the barometer, are you not?

DR. PETER J. DELANY: We'll have the national barometer and then each State will have its own barometer, which will have the national data. But we'll also have State data that they give us that we're going to incorporate. That's -- we're still figuring that one out.

MS. PAMELA S. HYDE: Yes, so this is complicated. And of course, as soon as we say this, somebody says, well, I want my city data, and we're not even beginning to be there yet. But it's an important question. Especially around prevention issues, it's really important to know you can have a particular community that's doing really well on something like binge drinking, for example, among high schoolers or among college kids, but the State is doing horrible. So what's the difference?

And even some of the RFAs that we're putting out, which kind of goes back to how we use our money to manage this stuff, too, to the States about prevention dollars in the substance abuse world is trying to say, okay, we're going to give you this money. What we're trying to do is actually change the data about underage drinking and prescription drug use, for example. And so, you have to pick a community that's high need in that area and you have to tell us how you see the community, the community you picked and what it will do to change your State's trajectory.

So State of, pick one, New Mexico decides they want to pick Tucumcari as a high-risk community. Well, how is that going to change the State's numbers about substance abuse, about prescription drug abuse?

Now in some ways asking them that sort of drives them to the big cities, and that's not necessarily a good thing. On the other hand, it should drive States to the communities that are having the biggest problems that actually can change

some of the trajectory of the way the State's data is coming out about this.

Again, our goal is, because we can kind of sort of see just anecdotally, and we're going through some process -- if Fran were in the room, she could talk about -- oh, she is in the room. Fran? I'm trying to describe this, and I'm looking out there. Where's my prevention people?

But we're trying to go through some -- look at data and what we can see because we can see differences in our grantee States or grantee communities, but we don't necessarily see the country changing on these. So that's what we're trying to figure how to do.

DR. PETER J. DELANY: There's one other thing. I mean, we're working with CSAP, with Fran, with Paolo, and a brand-new project called C-EMS, which is Community Early Warning Monitoring System. We're just getting -- we're working with AHRQ and USDA right now to find a way to define community. Because if you've seen one community, you've seen one community.

And that dataset will be helping us think about -- and the whole idea is to have communities identify their own data, put it up, but having some parameters on that and then use that to start thinking about how is their community doing on certain trends that really emerge into problems in behavioral health.

So I think we're getting to the point where when I first came here the first time, we really just had the kind of upper here State kind of stuff. Now we're starting to move deeper into the States, but we're moving into the communities. We really are going to have a continuum of ways to put it together. Now we may not put it all together, but we will help people think about how do you take your community data, put it in the context of your State, and what does that mean in context to the thing?

It also helps people think about, and this is the vision of SPF SIG, is you identify within your State the stuff you need to do, and then you put your money there. And then if you do that right, then that other data at the State and the national level is going to show. But then that's part of the report card. Did you put your money where your data was?

So that's all a part of it. It's exciting, challenging, and I think I'll stop here before Pam gives me anything else to do today.

MS. PAMELA S. HYDE: Fran, do you want to add anything to this, just about the way we've been thinking about this and prevention stuff? Because I'm thinking about even in the way we defined community for purposes of the PFS RFA that just went out.

MS. FRANCES M. HARDING: Right. We're trying to refine it. The problem is

that the board that we're working with doesn't really know what to do with half of the measures that our communities are using for collection. So we're trying to find definitions for almost every measure.

Parental disapproval. Parental disapproval for prevention is huge, and not every State or slash community collects that data the same way. So we're trying to figure out on the Federal level how do we find a way -- it's a great measure maybe. Can you define it universally, and how do we collect it universally?

So we're, as Pam was mentioning, the Partnerships for Success grants, we are trying to narrow down not so much the community, but the effect we want on the community. See, the issue with community is the science tells us you have to define your own community because as evidence of yesterday, if you talk or try to come up with one definition, it's not going to meet your community. It's going to meet mine, and it may not meet yours because you're in a school and you're in a community and you're in a hospital, and et cetera, et cetera, et cetera.

So someone had mentioned yesterday you can't do in the urban centers community. Yes, you can. A community in an urban center is a block. It's maybe two blocks. So we're having some difficulty because prevention is so specific to the data which is showing us the highest risk, and it's really hard to try to collect that. And then if you're a large State, you've got the same amount of money as a small State, and you're doing 3 communities versus 15 communities, how much impact are you having?

But it is, I will say, maybe not fun, but challenging from my perspective. But working with them is fun.

[Laughter.]

MS. PAMELA S. HYDE: So, actually, I should give Fran a lot of credit here. She is being willing to be the guinea pig for what I see as trying to move SAMHSA into sort of a learning community that helps the whole country learn. Because data, to me, is not absolute, and it's not -- report card is a good conversation or good way to describe it, but it's not report card in the sense of you get a D and you don't get to go to the party this afternoon. It's more of a "How are we doing?" kind of thing.

So, and we challenged Fran in her area because prevention is so important to us, and I know sometimes being the top priority is not the most fun because people are all over you. But we've really challenged prevention to say let's really step back and say what do we know? What do we not know? What is it telling us? What are we learning from what we're doing?

And let's challenge ourselves to say, well, if we're putting all this money out and we're getting these good results, and 20 percent here and 20 percent there, but

the country is not changing, then what do we need to do differently? Or what that's telling us? Or we're putting it out, and we're getting a 5 percent change. Is that really worth the price?

I mean, just those kinds of conversations. Not that anything is wrong, not that anything is bad. It's really to help us do a learning community.

And Fran, I should tell you that Dee is an old history -- has an old history with me in doing this kind of work from years and years and years ago, but she taught me a lot about how to use data to be a learning community and an organization. So you might want to share that with her.

All right. Other comments about the data stuff? Anything? It is now -- yesterday, we were hot. Today, we're cold. All right. The finally got the air conditioning to shift. Actually, I think it just changed outside. That's what happened.

All right. Any other comments about the data or about anything that Pete and Lisa presented? This has come a long way, and just to show you how far along it has come, I actually didn't even look at the presentation before they did it. So I'm having great faith that we're getting on here. It's great.

Thank you, guys.

DR. PETER J. DELANY: It's everything you wanted it to be and more.

MS. PAMELA S. HYDE: And more. That's right. Thank you. Appreciate it.

Agenda Item: National Dialogue Discussion

So we have just a few minutes before lunch. We can either break now and a have a longer lunch, or we can do what we said was on the agenda. We kind of touched it a little bit, and that's why I just want to know if we still have things to talk about here is the national dialogue discussion.

What we know is happening is the White House literally is planning its launch event now. We're working with them to plan that launch event. You heard kind of a piece of it yesterday. The national dialogue is conceived in sort of three pieces.

One is the community conversations that Carolyn really talked about yesterday when she took us through a little bit of a little taste of it. It's a whole set of stakeholder public-private partnerships. So everything from high school principals to YWCAs to behavioral health communities who are willing to say I'll

go -- my commitment is I will go talk to PTAs in my community about what would it be like if you brought your child in for mental health treatment. So to kind of demystify the process.

So those are just examples of, excuse me, some of the public-private partnerships that are being cultivated out there for the launch. The third piece of it is this whole electronic media piece. So there will be things launched in social media, on the Web, and other things to try to get at, frankly, the lay public.

So here I'll use the word "consumer" not the way we normally use it, but to mean just your consumer of information. Sort of I always think of this as my mother in the elevator kind of thing is just the person who doesn't particularly know a lot about this but is hearing a lot of conversation about mental health. So what is mental health? What does diagnosis look like? What does schizophrenia mean? How do you get help for that? How would you know it?

Just some really basic information. And then also generating, this is the electronic piece, it's just generating some conversation, raising the volume in the conversation by social media, videos, other kinds of things that people are going to do. So, anyway, there's kind of those three big pieces to the national dialogue, and they are all still emerging and the shape of them is still emerging.

But I think we're getting closer and closer to an actual launch date. I can't tell you yet because we don't have a final. But it's getting there. And there's lots of people and lots of big people involved.

So does anybody have any other conversation or reaction to yesterday or just questions or thoughts about national dialogue on mental health and what we should be thinking about as we respond to requests for information or requests for input about how this emerges?

[No response.]

MS. PAMELA S. HYDE: Are you thought out?

MS. CASSANDRA PRICE: This is Cassandra Price.

One thing that I've thought about when they were talking about targeting the cities, having that dialogue, and making sure that you are not using just the boilerplate, that you kind of assess where that city or those communities are at on this issue.

Like, I mean, I know you don't have time to do a big global assessment or needs assessment, but really understanding the dynamics by using those partners in those States and cities so that you kind of make sure your dialogue is meeting that need. And so, it's not kind of all boilerplates in every area. That's just one

thing that occurred to me to be successful.

You see that in the recovery community a lot.

MS. PAMELA S. HYDE: Yes, that's a great comment. The way these cities and dialogues, I don't know that we spent too much time talking to you about that piece of it. These cities, whether it turns out to be 5 or 10 or whatever, the few to begin with that are going to do the more formal, structured approach, really are all being led by the local mayor. So the mayor, we started out saying the mayor has to be willing and able to convene this and call it on behalf of the community.

And we were looking for a range geographically. So you saw that a little bit. A little bit of a range of size. So we've got relatively small communities to big, relatively big communities. And frankly, it's practicality. I mean, we were looking at the combination of local community organizations willing to jump in and play and also, frankly, local funders or national funders willing to put dollars in to do it because these are not going to be Federal meetings. So we're not putting one dollar into the meetings.

So in order to make them happen and to do the representative sample of the community and all that, it does take a little money to do that. So these communities really are to kind of seed the process and to try to be the more formal structured process, and then we hope there is some organicity to this that emerges.

We actually talked to New Orleans as well, but you guys were a little bit further ahead already in having the conversation about this and had already created some structure. So there's a few other communities like that that we've talked to where mayors may be very interested, but either it's not the right time for them or they're in a different part in the process or whatever. So, hopefully, some of that will emerge as well in different ways.

MS. CASSANDRA PRICE: And one thing that I would say that you guys have done, had some strength on is your policy academies that you've done recently. I participated in the veterans policy academy, and Georgia is going to do the homelessness policy academy. And the framework for that sometimes about really organizing, even though it's usually at a State partnership level, but using that at the community level of all the stakeholders that you get involved to build their action plan and then to seed that and bring it further out might be helpful because I think that they've done a good job with those policy academies.

MS. PAMELA S. HYDE: Okay. That's interesting because we used that analogy with one of the funders we were talking to when we were describing it to them. So glad to see that that has some resonance. Yes, okay.

Other comments about yesterday or about the concept?

DR. MARLEEN WONG: It was just kind of reminiscent of what happened in Los Angeles after the riots, and the community, as it was defined, was the areas in which the riots and fires had sort of damaged the city. But it was a very similar process, and it had some, I think, very positive outcomes.

MS. PAMELA S. HYDE: Great. Thank you.

Kana, I don't know if you're still on the line? If you are, you're probably muted. So I'm giving you some time to think about maybe unmuting. So, Kana, if you're paying attention, I know you've been talking lately, and I'm doing this partly because Paolo is not in the room. But the two of you have been working on the toolkit and some of the interface with the White House.

Do you have anything to add to this conversation?

MS. KANA ENOMOTO: I think the thinking in the policy academy direction, and I think that will be we're trying to do multiple things in one day. And when we're getting a representative sample of folks in the room and we saw how energized and passionate people were yesterday in the science council, and that's by and large everyone we had in the room was a behavioral health person. There was one non-behavioral health person as a speaker.

I think it will be part of a process that we hope to have come out of it is actually to have some difficult conversations so it's not just to charge in and, okay, everybody, let's do some action planning on some policy strategies and programmatic strategies that we can do. But actually have people think about difficult questions like what does mental health mean to you, and what does it mean to our young people?

And people will have varied response to that. We heard that one dialogue may be advertised as the intersection of mental health and gun violence. Well, of course, we would probably discourage that, but we can't keep a community from hosting a conversation in that vein. And I think the hope is that although those are really delicate subjects, we would provide enough factual information and guidance in our tools so that people would receive information that would say people with mental illness aren't violent and adding more hospital beds doesn't actually reduce gun violence, et cetera.

But that you would actually have -- you know, I think we know that contact is an important way of reducing negative attitudes and discrimination. So by getting those mixed groups of people in the room, you have the opportunity to have someone that has pretty profoundly negative attitudes or let's just say very different attitudes than the prevailing ones are going to be involved about the need for forced treatment or more hospital beds or less privacy, et cetera. And let them interact with people who have lived experience and are in the system

and people who manage the system to say here are the reasons why that doesn't always work, and here are some other things, so that we can just normalize the conversation about mental health.

MS. PAMELA S. HYDE: Thanks, Kana.

So of the things, again, I don't know if we said it clearly enough yesterday because Carolyn was trying really hard to get through stuff really fast and get to people talking. But the idea of the 300 or 400 people per community that would be part of this 1-day community conversation, which, again, is just a part of a whole bunch of other things going on, about half of them would be what we call "ordinary citizens," people who have enough interest they're willing to come to a meeting, but are picked to represent the community demographically, racially, ethnically, et cetera.

By definition, you're going to get different people with different views in the room, and then the other half are going to be people from the either Government behavioral health interested parties, people with lived experience folks, and the interest is having a fair number of those be youth. So we're going to explicitly try to make sure there is youth there speaking and being involved because we're really focusing on the under 26 or under 25 year age group there.

So I don't know how well that came across, but the idea is to have youth voices very explicitly in the process as well. So it will be interesting to see how these emerge. And this is one place where the Federal Government, SAMHSA is really trying to seed this, encourage it, create the opportunity and the framework for it, create the background facts and figures that people can react to and a guide to know how to handle these conversations.

But you could have 20 people in a church basement if you want and do it, or you could have 1,000 people in a town hall and do it. We're going to try to do somewhere between 5 and 10 of these really structured conversations so we can sort of have a foundation that other people can build on about it. So, hopefully, that helps a little bit.

Did you have a reaction, Stephanie?

DR. STEPHANIE M. LE MELLE: More I guess a technical question, and I may have missed this in the presentations. So this is a 1-day event, and then there is going to be technical support to the communities that this is done in to sort of follow through? What happens after that? How is it going to sort of play out afterwards?

MS. PAMELA S. HYDE: The community conversation is expected to happen in a day, but part of what the deliberative democracy community is doing for us in connection with the funders -- they're raising the money, not us. Because all the

ones they told you about are nonprofits, and they do this work off of a donor basis. So they've been talking to foundations and other donors and givers.

The idea is to have enough money to do the meeting and then some money left for the community coalition of groups or whoever it is is going to carry this forward. They are creating a central Web site that will be the learning community for the 5, the 10, the 200 communities, whoever chooses to do it. They've done some thinking. Even before this happened, they had been doing some thinking about how to get multiple communities around the country to get lots and lots of people involved in the discussion.

So part of the discussion will continue in that community to implement the plan that they come up with that day with some dollars from foundations and others that do that. And hopefully, frankly, that will generate some other interest in community foundations and others to keep the thing going, and then also this sort of nationwide learning community that is electronic. That's separate from what the White House and we are going to do about Web site and other things for the general public.

So that's what I keep saying. This is very multifaceted. So it's hard to think about how it fits into the whole set of pieces, but does that help? So, yes, the goal is to have a plan. The goal is to have action steps. The goal is to have money left for a group of community organizations that have already committed ahead of time to carry it forward once it ends, et cetera.

And having the mayor's office involved, mayors are not being asked to put up money, and they're not being asked to put up the resources to make it happen. But they are being asked to be the conveners and, therefore, sort of responsible in working with their communities going forward to make sure something happens out of this.

DR. STEPHANIE M. LE MELLE: The other point I think that was raised yesterday is that it's going to be -- there's going to be some data component of it. I know I keep harping on data today. But that there's a data component. And is that going to be -- is it sort of going to be this is the national data that we know about behavioral health care and all of these issues, or is there going to be an attempt to sort of localize the data so that people on that one day would actually have a sense of what their local data was before the meeting?

MS. PAMELA S. HYDE: Only if the local community has it and is able to bring it to the table. What we are capable of doing is putting together some basic facts at a very high national level, some of the stuff that you've heard that we know that three-quarters of these issues start before the age of 24, for example.

I mean, for the basic public, they don't know that. They don't know how important adult mental health issues are in terms of impacting them and young

people first. So there are things like that, just basic facts that we're trying to get out there. And we are really trying to do it as fact-based stuff, not as judgmental.

There's a lot of people who have judgments and feelings and beliefs about it and believe they have information that proves that. We're just trying to take the facts that are available in the general public or available generally, whether the public knows it or not, and put it out in facts that we can cite to where the facts are coming from. And then let the facts sit for themselves.

Then the facilitators will bring out people's feelings and views about things, and I'm sure there are some people who will just disagree with the facts. They'll just disagree, or they'll say they have other facts, or that's part of the dialogue.

I am, obviously, as you could see yesterday, very passionate about this. But I'm a big believer in conversation is the place to begin. Yes, we can sit all day and say what we really need is more money for mental health services. And we could say we need more of this or less of that or more beds or more of this. Until we start getting people having the conversation about this, all it's going to be is a political hoo-ha about how much money we're appropriating for what thing, and that is not going to make a sea change shift in our country about mental health.

And I do like to think that SAMHSA can be helpful in that sea change. So that's what we're trying to do.

All right. Other comments or reactions to this idea? You guys, Charlie or Megan, have a thought about -- since we're so focused on youth, about this effort? Anything you would add to this?

MS. MEGAN GREGORY: I was just thinking about the future of SAMHSA and where you guys are headed and what I would like to see. And something that really bothers me in my State is we don't have access to gyms. And to me, exercise is crucial to your mental health. I mean, I know I feel better after I go running.

And so, I would love to see health consortiums collaborating with a gym to provide affordable access to those facilities. Because in Juneau, I pay $100 a month for a membership. It's ridiculous. And in rural communities, they don't have access to anything. So that's one of my concerns that I think that I want to focus on in my State.

And I also think nutritional value. We don't have access to fresh vegetables, and so something I'm promoting within the rural communities is gardening because not only is it therapeutic, I think that once they start growing their own fruits and vegetables, they'll be more inclined to get with their family and cook them for dinner. And we get our food barged in. So it's 2 weeks old, and it lacks nutritional value, and all of this goes hand-in-hand with I think it leads to a

healthier lifestyle when you focus on these things.

And it helps with smoke cessation. If you have access to a gym, you feel better about yourself. You won't have the issues with diabetes, and you know, health consortiums can collaborate with gyms so it can -- you can work with people who have issues with physical therapy. And I just think there are a lot of ways that we can collaborate, and I think that we also need to work with housing authorities.

The gentleman yesterday mentioned working with housing authorities, and I think it would be great if they promoted people having their own plots and greenhouses. I think every school should have a greenhouse. We could incorporate different languages. We can incorporate science.

I was talking with Charles about this yesterday and just how it creates a sense of community. So those are things I think we should take into consideration when we focus on prevention and treatment, and that's just something I wanted to point out.

Thank you.

MS. PAMELA S. HYDE: Great. Thank you.

Paolo might be able to add more to this, but I had the opportunity a couple of years ago to visit a program in Tucson. So it's a small city, but definitely a city, not nearly the challenges that you're talking about in Alaska. But they are one of many, I think, now mental health programs that are doing an incredible set of work at creating essentially what amounts to a spa or a gym for people with mental illness.

And so, they come in and they get their weight assessed and their exercise ability assessed, and they go through just what you would do if you were going to go in and get a personal trainer. And they go through the process, and they've got exercise weights and stuff there, and they're taught how to use them. And it's pretty amazing.

And they have lunches that are nutritionally developed and stuff, and it's pretty amazing at the amount of smoking cessation, the amount of weight loss, the amount of just graduation from somebody who could not walk up one set of stairs who is now doing that and feeling really good about themselves. It's amazing.

So your point is well taken. And that's just one program that I'm aware of, and I think there are others emerging in that way.

DR. MARLEEN WONG: I really like the way that you're thinking about this. It reminds me of in Israel where it's a country born in war. It's still in war. They

have a model of psychological first aid, which they call talking and walking. They don't sit and talk with people. They walk literally down not a street necessarily, but in a neighborhood and talk about the impact of the Katyusha rocket falling near their family and how that's been so distressing.

So I think we need to look at new, integrative approaches.

MS. PAMELA S. HYDE: Yes, if we can do it over the Internet, we can do it while we're running and walking, right, Megan?

That's great. Those are great impacts.

Yes, Charlie?

MR. CHARLES OLSON: This is Charles.

Kind of going off of her idea and her -- Megan's examples, there are so many other different types of alternative methods for well-being. There is -- I have a friend that's a volunteer on warm line, and he swears by acupuncture. There is meditation, art therapy.

And for SAMHSA looking forward, I think that in a lot of these there's a lack of evidence, a lack of science behind it. But I would like there to be more, and I would like that SAMHSA take a look at those because there are so many different pathways to wellness. Aside from just empowerment and medication treatment, there's just a lot of options.

MS. PAMELA S. HYDE. That's great. Thank you.

Again, Paolo had to leave, but there's a lot of work going on in the recovery support initiative around wellness and stuff, which we've kind of jumped on the bandwagon of the Million Hearts campaign, which is about hearts, diabetes. Well, the idea is to prevent a million deaths or incidents of heart-related illnesses. So they're focusing on diabetes, on cholesterol, on ABC, the aspirin is for heart. B is for -- I can't remember it. Sorry. It's time for lunch.

Anyway, but it's based on those four major, three or four major issues, and we've really jumped on that bandwagon and have used that in our mental health and substance abuse wellness campaign issue. So you guys are right on target.

Okay. Any other questions or comments about the national dialogue issues or anything else of this nature?

[No response.]

MS. PAMELA S. HYDE: All right. We're going to break for lunch. We're going

to give you an hour because, frankly, a couple of us have to go do some budget stuff. You want to tell people about lunch?

MS. GERETTA WOOD: Yes, today I'm going to have you go over to our little cafeteria, which is just next door, and just get lunch there since it's just our one council. And a reminder that the honorarium form is in the back of your notebook, and if you could complete that and leave it here for me over lunch, that would be great.

Thank you.

MS. PAMELA S. HYDE: And we have two big topics after lunch, but we're going to do them fairly quickly. So we'll start right at 1:00 p.m.

Thanks.

[Break.]

MS. PAMELA S. HYDE: Okay. By the clock on our wall, it is 1:00 p.m. So for everyone on the phone, we're going to get started, and I think most of the folks are back around the table. Gosh, you all are on time. That is very good.

So this next session is about the behavioral health workforce report to Congress. There are a couple of people who have done tremendous work on it, and one is Linda Kaplan. She's going to present here today. The other one is Miriam Delphin-Rittmon, who came into the middle of the process, but since then has begun to work with Linda to provide some leadership around workforce issues in SAMHSA.

Miriam works in the Office of Policy, Planning, and Innovation. Linda works in the Center for Substance Abuse Treatment. And they both have different, but varied backgrounds on some of these issues. So we're really pleased to have them helping on this issue.

And as I said earlier this morning, we haven't really decided as SAMHSA completely what we're going to do about the workforce issue. It is HRSA's lead on workforce in general. SAMHSA has lots of authority and obligation to do workforce improvement, but that's different than developing the workforce, per se. And we've had up until the proposals that you heard that are in the FY 2014 budget, we've had really only very small programs around workforce development beyond the training and technical assistance part of it, which we do do quite a bit of that in a variety of ways.

So, with that introduction, let me let Linda do this. We're going to have her just present for about 10 minutes or so, and then the center directors are here to have the conversation. They're not all going to present at you, hopefully,

although if any of them want to say anything, they certainly can. But we want to have the interaction with you about this issue.

So, Linda, let me let you take it away.

Agenda Item: Behavioral Health Workforce Report to Congress

MS. LINDA KAPLAN: All right. I think I'm ready to go. We have a stopwatch. I'm 10 minutes.

I'm just going to very briefly go over this is like a 50,000 view of the report, which I think you all got in your notebooks. It's wonderful reading, but I'm just going -- no, it actually is interesting. So I'm going to hit the major focus areas, which are sort of the changing landscape, give you a very brief overview of demographic information, workforce conditions, some of the workforce needs, a very, very brief overview of workforce programs, which the center directors can fill in a lot more. Some of HRSA's workforce efforts and some of our collaborations with HRSA.

Just to give you some context, as you all know, there are only about 11 percent of people not even -- who have substance use disorders receive treatment. About 38 percent of the 45 million people who are reported to have any psychological distress receive any mental care.

We have almost 9 million people at least who have co-occurring disorders, and there are also an increasing number of veterans who report mental health and substance use disorders. And also there is many of the States are really trying to reduce prison population. So you're going to have a lot of people reentering the society who really do need both mental health and substance use assistance.

So we're now going to go to changing landscape. Well, we do know that the health reform and parity are going to increase access, one would hope, to behavioral health care issues. And I know this morning, as someone was saying, that about 11 million more people will be identified who will need behavioral health services.

We all know there is more research and advances coming into the field, and there is a real push to accelerate the rate of adoption of these evidence-based practices. SAMHSA has been in the lead, I think, in terms of really shifting to person-centered, recovery-oriented care, and I know that you've heard a lot about that. But it really shifts how we do our care.

The other thing that's going to be apparent and is already apparent in many ways is the whole utilization of multidisciplinary teams as we integrate behavioral and primary care more. So we need a workforce that's prepared to work as part of a team, understands recovery principles, and understands what person-centered and person-directed care is.

In addition, we're really looking at this as a chronic care model for both substance use disorder and mental health disorders, and we're looking at much more of a focus on prevention and long-term recovery. So, again, the workforce needs to be prepared to do that. We are having our system shaped much more by people with lived experience. There is going to, again, be more use of screening and brief intervention, referral to treatment, and we also know that recognizing impact of trauma on both behavioral and physical health.

So those things are going to impact sort of how we deliver services, and the workforce needs to be prepared. In addition, though I look around this table and it's not true much here, really the population is aging. And this is a much younger group than I'm used to dealing with. Right. I know that you have.

So let me quickly go into the demographic information. Except for some of us. And just quickly, this is a predominantly female-dominated field. Except for psychiatrists, lo and behold. Dr. Clark is an example. Minorities are underrepresented in all of the professional groups and among peers as well, at least of the data I have.

It's an aging workforce. A median age ranges from counselors that are about 42 years of age to 56 years of age for psychiatrists, and in fact, almost 50 percent of psychiatrists are 65 and over. Mental health professionals almost all have a master's degree, and 55 percent of addiction counselors have master's degrees.

Workforce conditions. I'm just going to -- okay, here we go. We have a high staff turnover, ranging from 18 percent to 33 percent. That compares to about 7 percent of physicians and 11 percent of like nursing and other staff. So it really is much higher than even the rest of healthcare. We have workforce shortages. Fifty-five percent of counties in the United States --

DR. STEPHANIE M. LE MELLE: You said it was 7 percent?

MS. LINDA KAPLAN: I think it's 7 percent, the last data, and I'll check. About 11. I mean, we're really way ahead of them, unfortunately.

We have many rural counties that have no practicing psychiatrist, psychologist, or social workers. I don't know how many of you know I love using this term, HPSAs, but there are these health professional shortage areas, and in mental health, there are 3,669 around the country. This is in the U.S., and it would take -- what? Did you have a question? That's coming out of my 10 minutes, but --

[Laughter.]

MS. LINDA KAPLAN: So hurry up.

MS. CASSANDRA PRICE: I like you. You're cracking it. I just have a -- and I can't let this one go. My name is Cassandra Price, and I can't let this one go. I've been really good this meeting, I'd like to point out.

But we recently had some technical assistance, and I won't name who the person was. It was actually very thought-provoking about efficiencies and providers and a new world, and it was very, very thought-provoking. The consultant challenged us to say that we really don't have a workforce shortage, that this is a myth, that the problem is that we're not paying and incentivizing. We're not using efficiencies.

So I just throw that out there. Because it really kind of blew my hair back I believe this data, and so I just bring that to your attention that that's something that was very earth-shattering for me to think about in a different perspective.

MS. LINDA KAPLAN: Well, honestly, I'd love to see the data because the data we've seen says the opposite. So I don't know.

MS. PAMELA S. HYDE: Cassandra, let me underscore something here. The fact is the Nation has no data, none, about what we should have compared to what we do have. There are lots of -- there are professional groups like school psychologists, and I'm not picking on them. I just happen to know what they say. And they've got a number that they say there should be X number of psychologists compared to X number of students.

That is their assessment of that. There is no national way to assess that across all the professions. That's a part of the issue. So people do make wildly differing statements about need, and I think you're going to see later I think that's part of the issue. But your point is well taken.

MS. LINDA KAPLAN: And I agree that -- I think there are some areas there is an overabundance of mental health and substance use disorder workers. So, again, part of it is maldistribution is the issue, which is why you have these areas that have no professionals at and others too many.

MS. PAMELA S. HYDE: Excuse me. I'm sorry. We are taking your time, Linda.

But the other issue, and I did some work about this in my home State of New Mexico before I became a resident of the State of New Mexico, and they have X number of child psychologists. Most of them are in the Rio Grande Valley, which basically means they're in the center of the State, focused in University of New

Mexico and some in Las Cruces, which is another big State -- I mean another big city. But most of the child psychiatrists who are at the University of New Mexico don't practice.

So there's also a distinction between the numbers and what they're actually doing. So that is both maldistribution and what they're doing.

MS. LINDA KAPLAN: I'm sorry. Just like the HPSAs are based on a certain ratio of psychiatrists and psychologists and social workers to population. So it gets -- it is. It's a little confusing. But this is the data we have.

And so, according to HRSA, it would take 1,846 psychiatrists and almost 6,000 other practitioners to fill the slots that are needed. We do know that -- or I shouldn't say we know, but there are certainly lower status and discrimination associated in working in behavioral health care. And in part, that's reflected in lower compensation, and I'm just going to give you two examples.

Master's level social workers in behavioral health earn about $45,000 a year, and in general healthcare about $50,000. Nurses in behavioral health care earn about $53,000. In healthcare, in a primary care hospital setting or whatever, they'll earn $66,500. So you can see there there's a big discrepancy. And actually, I think as we move more toward integrated care, it is possible that salaries will increase as we go down the road.

Just quickly -- I hope this works. Well, I'm going to do workforce needs and recommendations. Here it is. Competencies -- well, I talk really fast. I'm from New York. Competencies and working in integrated -- these are what we think -- what we recommended anyway.

Competencies and working in integrated care settings, and we have the Center for Integrated Health Solutions that's working on that. Training and education on recovery-oriented care and recovery principles. We have recovery practice efforts, as well as BRSS TACS. Use of technology, including electronic health records is BH Business, which is really targeted toward providers, a very exciting program.

Competencies in co-occurring disorders, which is something that we really need to promote and look at. Dissemination and adoption of evidence-based practices, and we have the ATTCs, the CAP, and the TA centers that do that. Recruitment of a more diverse workforce, the Minority Fellowship Program, the National Network to Eliminate Disparities, NNED. Standardized workforce. Data collection, we were doing some work with HRSA on that. And the increased role of peers and other community service workers, which is through grants and BRSS TACS and all that. So we have that.

Some examples of SAMHSA's workforce programs are technology transfer and

training on evidence-based practices, and I'm just giving you one or two examples in each -- so don't think that's all we do -- are the ATTCs, manuals, publications, and other resources would be the CAPs.

Supporting knowledge transfer. The TA centers, such as on suicide prevention and trauma. Recruiting a diverse workforce, which we really do need to do. The Minority Fellowship Program, the NNED, and prevention fellows, which have concentrated on that as well.

In terms of integrating primary and behavioral health care, we have the CIHS. We have the SBIRT residencies, and we have physician support systems. We have peers in recovery, recovery-to-practice, and BRSS TACS, and preparing for health reform, again BH for Business.

Just very briefly, some of HRSA's behavioral health workforce programs. They have 5,000 behavioral health practitioners in FQHCs. They have over -- of the 10,000 National Health Service Corps awardees, about 3,000 are behavioral health practitioners, and that's really gone up over the last few years. They have a graduate psych education program that provides training for working with underserved populations, and they have 710 psychology students in that.

And then last year they were able to fund finally, because this was actually authorized in the ACA but didn't get funded until last year, the mental and behavioral health education and training grants, which will increase the number, hopefully, of social workers and psychology students in accredited programs and increase those in the field.

Lastly, it's just some of the work that we've done with them, and that's -- the first one is the Center for Integrated Health Solutions, which provides training and TA on integration of primary and behavioral health care. They've done some wonderful things. I urge you to go to their Web site.

We've collaborated on training for the NHSC awardees that I talked about, coordination of training and education in HBCUs through contracts we both have with Morehouse School of Medicine, providing behavioral health materials for FQHCs, working with other HHS agencies on training of community health workers on SBIRT, and we've had some recent collaborations last year on the minimum dataset, which was to hopefully start collecting some minimum data across different professions in military culture training. And we had a joint stakeholder listening session.

And that's it. Thank you. As I said, really fast.

MS. PAMELA S. HYDE: Thank you, Linda. I really did push her to do this quickly.

If I can direct your attention to the report itself, if you go under the tab that has that in there, if you look on page 47, and then I'm going to go take you back to 45, we worked carefully on the language of this first paragraph -- actually, all three of these paragraphs of the conclusion -- because we wanted to while acknowledging the issues in that workforce, we did want to acknowledge how dedicated and passionate and capable they are.

We called them "a small, but mighty force working to protect, maintain, and improve the health of America." The next sentence there is what I frequently say is we're too white, too old, too underloved, and too underpaid. It's the workforce is too few, aging into retirement, inadequately reimbursed, inadequately supported and trained, and facing significant changes affecting practice credentialing, funding, and ability to keep up with changes and practice models stemming from changing science, technologies, and systems.

And then it talks about some of the new populations coming in. So the aging population with behavioral health issues, the veterans and service members populations, et cetera. So we tried to sort of sum it up there.

If you go back to page 45, it references the joint listening session that Linda talked about that we held with HRSA last June and what came out of that. So it's in four areas -- behavioral health workforce capacity, then data needs and collection processes, training and education needs, and the nontraditional workforce. Those were the four areas.

There are some points or themes I think it's slightly less than recommendations. We were really reporting what people said. They are not particularly in any order of priority or otherwise, but basically sort of encapsulating what that group of stakeholders, which I think pretty much represented the range of people from providers to States to practitioner groups, et cetera, in that, and consumers and others in that meeting. People in recovery as well.

So, with that, the floor is open if anyone wants to comment? Yes, Stephanie.

DR. STEPHANIE M. LE MELLE: Stephanie Le Melle.

Over lunch, we were actually talking about telepsychiatry, which I didn't really see in the report. I didn't look that carefully in the report, but I don't think I saw it in the report because I think that one of the ways to multiply our providers is through telepsychiatry.

And I think as we were talking about at lunch time, there are all sorts of little things that need to be tweaked in terms of the risk and licensing and who does what and where the medical record lies, and who's responsible for what. But it really does work, and particularly in areas that are really underserved, and there are lots of good models out there now of how it's being used and how it works.

MS. PAMELA S. HYDE: There actually is a bullet. It doesn't say telepsychiatry. It probably should. But it says encourage the use of technology to expand the reach. Do we have it in there? Because what I see is the use of technology. Okay. It's been a while since I looked at this myself.

Probably could be pulled out more, though. I think your point is well taken.

DR. H. WESTLEY CLARK: And we are working with HRSA and others to establish that in addition to, as Leighton Huey pointed out at the CSAT NAC, sometimes the issue is bandwidth and not the central capability at the originating site. So we're working with HRSA. They've now set up a behavioral health, tele-behavioral health process, and then we're working with the FCC and USDA on the issue of particularly for rural areas expanding bandwidth so that you can get actual interactions.

People get freaked out with pixilation. So that doesn't make for good therapeutic interactions. But yes, we're trying to promote that along with electronic health records and the sharing of information.

MS. PAMELA S. HYDE: Charlie? Do you prefer Charles or Charlie?

MR. CHARLES OLSON: Either one is fine.

MS. PAMELA S. HYDE: Okay.

MR. CHARLES OLSON: This is Charlie Olson.

I was kind of curious on the official standpoint. Is telehealth being treated as a replacement or kind of a if you can't do a face-to-face, then this is your next best bet? Because I know that there's a lot of controversy about the actual effectiveness of some of the behavior interactions that come out.

DR. H. WESTLEY CLARK: Depending on the issue, actually for CBT treatment, Web-based cognitive behavioral therapies have actually worked very well. And rather than an either/or kind of a proposition, it is something that leverages limited resources. You can conceptualize it as certain not only geographic situations, but population-sensitive situations where perhaps it might be ideal if you had a face-to-face, but the ideal is not operating in that environment.

And then there's the issue of some smartphone-based interactions between therapists and client that allows texting and emergency contact or near-emergency or urgency contact between the provider and the client without encumbering the whole process. So the issue for the American Psychiatric Association, American Psychological Association, and others is just finding that nice mesh between access because most clinicians don't want to be available to

their clients 24 hours a day because I can tell you working with some clients, that does happen.

So, but you leverage access, and that's why broadband is important because it's moot if you don't have access to it. But it shouldn't be seen as an either/or proposition.

DR. MARLEEN WONG: We actually started a telehealth clinic in our School of Social Work last year. We've seen about 1,000 clients. And what we've found is it's first, at least these early learnings is that it is for certain populations.

For instance, it's interesting, younger people, they live their lives and interact socially, and so they feel really very comfortable on it. We've also found that some military personnel don't want to be in public, do want to have service, and also find that beneficial. But as Dr. Clark said, the cognitive behavioral therapies are pretty effective, same as on the ground, and we found that the clinic works fairly well.

It's the structural issues that are a challenge for us, how we align with other Medicaid-providing agencies. We talked about if you're licensed in one State, but you're seeing somebody else in another State, what is that?

And in terms of bandwidth, what we did was we donated some computers to local high schools because we found the students wanted to have counseling but couldn't get on a bus and go somewhere by themselves necessarily or had to go through dangerous territory. So that's been successful as well.

MS. PAMELA S. HYDE: I think it's also important with telehealth or telepsychiatry, or tele-whatever we want to call it, to talk about -- to think about what you're talking about because there is some consultation that's very effective, which is actually almost for the provider, but the provider who's on the other end of the wire needs to be able to see the interaction with the client. And I know that payment gets to be an issue there.

So I know we were dealing with that when I had responsibility for Medicaid was just to make sure both practitioners could bill at the same time. You had to have some way to do that. Otherwise, it was seen as a conflicting billing arrangement. So there's lots of stuff in it, I think.

And then just purely consultation with providers who may be out in rural areas. And so, again, using the New Mexico example I was earlier, a lot of the University of New Mexico-based psychiatrists don't do direct service, but they will do consultation out with areas that can't get into the cities easily. So --

DR. STEPHANIE M. LE MELLE: And just add to that, I think one of the other ways that we use it in New York frequently is in the criminal justice system and

doing consultations in the prisons where it would just be really difficult to get a clinician out to some of these places. And I was just thinking as we were talking about earlier, also with supervision. I mean, it could be a really unique way of using telepsychiatry for supervision.

DR. PETER J. DELANY: There is a related issue --

MS. PAMELA S. HYDE: Pete, you need to say who you are.

DR. PETER J. DELANY: Oh, sorry. Pete Delany. I'm used to the camera.

A related issue to the telehealth is also teletraining. I know a number of schools of social work are doing a lot of online training, but they have to work around how do they get the person-to-person aspect. There are a number of the not necessarily traditional universities, let's use that term, that are going fully online to train their clinicians, and the question is then what kind of skill sets do they have when they actually have to interact with people? Because there's no requirement.

Now then they go into the field, and they're seeing clients for the first time as they're trying to get their licenses. So I think part of this as we go more and more using online, I mean, it's a perfect thing for distance. I actually, when I was at Navy, did a lot of supervision using VTCs because especially when they were over in Afghanistan and Iraq.

But if we're going to move this way, we have to understand that we're going to move toward training clinicians online, but we also have to think about -- and this is where SAMHSA can help, I think -- setting standards for other components because you can't just do everything online. It doesn't make sense.

MS. PAMELA S. HYDE: Well, the interesting thing to me is we're talking about telehealth or telemedicine, assuming you can see the person. But there's an increasing amount of therapy and online email interaction when you can't see behavior at all. You're just dealing with the written word. So we all know how differently emotion comes across in emails. Even if unintended or sometimes if intended, it doesn't come across, or vice versa.

So I think all of those things. And there certainly are practitioner groups who are saying that's not ethical. It's not good. Well, you know, we're going to have to get a life because it's going to happen. So we're going to have to figure out how to do it well. And so, I think it raises the issue of are we even training people as they go through school how to deal with these kinds of interactions?

I think Fran had her hand up, and then we'll go this way.

MS. FRANCES M. HARDING: I just wanted to say that the technology and

electronics in general has taken off in a big way in prevention. Both for the college campuses, the high schools, middle schools. They have even -- we're working with Dr. Clark and his health technology team looking at putting kiosks in the lobbies of middle school and high schools so that they can go in at their own leisure, and it's a little bit of a game to be able to get some of the information that they need.

Training, much of our training is now in electronics. But the most, the newest cutting edge is education to parents, letting parents know. This came out through the prescription drug misuse field, just learned about this, that many States, particularly Florida, are beginning to give out messages to parents because they're one of our hardest to reach populations when it's around that area.

So the only caution, though, we learned this week in our NAC is that on the college campuses, they've learned to use technologies to their advantage in advancing parties. So they go from one party to the next, and once you're on someone's list for even a good reason, you can also use it for a social reason. So it's an -- I mean, kids are very innovative, and that's what we want. But not in that way.

DR. BENJAMIN SPRINGGATE: I'm Ben Springgate.

I'm interested in, after hearing the presentation and hearing the discussion, if we think now 10.8 percent of the 21.6 million people with substance use disorders receive treatment, and 38 percent of the 45 million people receive mental health care, and we're saying to ourselves, yes, it's great. It's good. We're thrilled that so many people are going to be covered through the Affordable Care Act.

But the providers that exist now and the tools that we have to provide services now, they're booked, right? So even if we use telehealth, we're essentially taking a provider who could be seeing -- I mean, in some cases, it could promote efficiency because the doctor or provider doesn't actually have to move from place to place. So maybe some gains there in efficiency. But essentially, the workforce is booked. It's aging and retiring faster.

We have some new training programs, you know, online training programs, as an example, an emphasis on master's training programs to get more people out of the pipeline. But I'm wondering a couple of things.

One thing I'm wondering is are we going to see that substance abuse and mental health disorders are going to be -- the level of services available to people is going to be downshifted onto lesser and lesser trained or credentialed providers because of simply the population burden and the workforce shortage? Or you know, that's one possibility, and that doesn't mean necessarily there's going to be worse outcomes. There could be just as good outcomes, depending on how that evolves.

Are there existing models maybe that we can point to in the private sector or elements of public sector service delivery around the country that we can say this is really efficient? This is really an exciting way that needs to be shared in our learning collaborative or something like that.

But I'm struck that at least for the short term, starting January 1st, there's going to be a real upsurge in demand, and not a lot of -- and one possibility is then that exactly what Cassandra pointed out, that the real problem, some people will approach it as saying, well, the real problem isn't that there's a workforce shortage. Up until now, you haven't been getting paid enough.

Well, guess what? My company will pay you enough, and then there's going to be a draw potentially to the highest-paying organization, which may or may not be paying for services or offering services to persons who are coming from the settings that we're historically used to talking about.

MS. CASSANDRA PRICE: This is Cassandra Price.

I think the salary issue is part of it, but I think I would challenge us to think a little bit further, too, about when we make the statement about that they're booked. And I'm not speaking for your State or your provider organizations. But one thing that we've found is when we really start looking at efficiencies and productivity and what we say is booked and what maybe really isn't booked and working with providers to streamline and be efficient and increase productivity and also looking at multiple payer sources and looking at all the ways that they can leverage what they do to become more efficient business models and practices, I think there's room there for improvement.

So I think that's just a critical thing sometimes we jump to, well, we don't have enough people. We need more bodies, or we need to pay them more. And I think that's part of it, but I think there's that bigger context of how we bring our providers along, who are very dedicated in this field and work really hard, but there's always room for that increased productivity and efficiency in what they do.

MS. PAMELA S. HYDE: Yes, Betsy? Go ahead.

MS. ELIZABETH A. PATTULLO: Yes, and I think Pam has alluded to this before, but I also think you will see new provider models emerging. You'll see people -- I got a call the other day from somebody who was doing some consulting work for a company I think that was not named from the west coast that wanted to know where there were gaps in Massachusetts in terms of the healthcare delivery system.

And some of that will probably be bad, but some of that's likely to be good. It's going to be some creativity and some energy -- some of it fear driven, some of it

opportunity driven -- that will come into the lifeblood of the system.

But one thing that has been an issue that I have observed, again, in mainly in the Northeast that I think my generation has done a lousy job on is at the leadership level, you know, I grew up in the deinstitutionalization of the juvenile justice system. And guess what? There all of a sudden emerged a provider community, and many of us got good jobs with good pay, and we sat there, and we didn't make room for the next generation.

We stayed forever as the executive director. We stayed forever as the whatever, moved around a little bit. But when Megan and Charles were coming up, you could work your butt off for a year, year and a half, and then we bet that you would leave the field and go off and sell shoes or do something completely different. And I think we've got a responsibility to kind of say to Megan and to Charles and to other people, you know what, not only is there an opening here that you could come in and fill. But there's a life. There's a career.

And at some point in time, I'm going to take myself out because, guess what, I don't have the energy for it anymore. I'm going to do something different, and I'm not going to just sit here and wait it out. I'm going to get behind you and see if you can't figure out some things that my bag of tricks is done. But help you kind of carry it on.

And I think there's an opportunity that we have across the board that's not just in healthcare, but certainly in this world to say we need people who are on a mission from God, who really are true believers who are in that next generation, and we need them to come on in and join this. And it won't be -- we'll never compete on the money. We will never compete on the money.

But we've got a hell of a mission, and if you can get a living wage out of that to have work that you love and that can sustain you and your family, what gets better than that? So --

MS. PAMELA S. HYDE: Yes, these are all good points. I wanted to make just a point or two about the data because I do think we need to think about the data accurately, and I'm as bad as the next person at trying to throw out data without describing it carefully.

But like the 11 million, there is no question 11 million is the right number in terms of our best estimate of the number of people who have behavioral health issues from serious to not so serious of the people who are going to get new insurance. However, that doesn't mean they aren't receiving some services now. Some of those individuals are receiving services through block grant or through county money or through the jail or through other places. So it's not necessarily 11 million brand-new people never having been served before. Some of them will be.

And then, frankly, of the other -- so out of 62 million people, we think 11 million are going to come into the system with full-flown needs. But there's another, what's the math there, 50 million people, some of whom are going to get identified that haven't been identified.

So there's also another group there, and I don't know that it's going to be hugely massive because the 11 million takes into account some folks who could be identified but maybe aren't well diagnosed yet or aren't in the system. So how many more of that 50 million is not clear yet, but some more will come in.

The other thing that I think, trying to remember the variety of comments here because I wanted to make sure we were clear about how we were talking about it. Oh, the productivity issue.

We also have tended to build productivity on a 50-minute hour, one person to one 50-minute hour. And obviously, people are already doing groups and things of that nature, but I don't know that we've done a really good job with telemedicine groups or with email groups.

And frankly, the data about almost 90 percent of the people with substance abuse needs not receiving treatment, we need to be clear about that, too. That's not receiving specialty treatment. We don't know that they're not receiving some other treatment some other places or self-help, mutual aid kinds of things.

So how many -- I don't think we totally know that number, Pete. And I believe that number is adults as well. I don't think it -- we keep talking about people, but I think it's an adult number.

DR. PETER J. DELANY: Well, it's 12 and up. But the other thing I think it's still something like one of my pet projects to look at that 90 percent of the people who are diagnosable who don't get care. That's actually the pie chart is what you're talking about?

One of my pet projects is to figure out where they are in the continuum because they meet that criteria that day when we do the data, but they may actually not be at a point where you really -- where Wes and I have been talking about this. The idea that these are the people we really want to get back up closer to the prevention end because they really meet a criteria, but the DSM is kind of -- it's not perfect. And when you're asking it in the interviews.

MS. PAMELA S. HYDE: When you're doing it as sort of surveillance instrument, yes.

DR. PETER J. DELANY: The way we're doing it as a survey. And DSM-V is going to make it even more interesting. So I think that -- I think that it's really, to

me, the real gap are the people who really say "I need help" and couldn't get it or tried and gave up. That's our real gap, and I think that's the 1 to 2 million.

But remember, we only have 1.9 million slots that we identify at least in the public sector. I think you might be able to double that when you add the private sector.

MS. PAMELA S. HYDE: Well, but that's the point. We're still counting slots in a particular way that don't necessarily reflect new models of service delivery. And the whole issue of the peer workforce, I don't think we know yet in any consistent fashion what the peer workforce can add to this or what pieces of the activity can happen.

And your point, Ben, about moving people into lesser licensed or lesser certified people, I would say that. I would say the same thing, but the other way around, which is are we using people at the top of their license? So could we make sure that the most highly trained people are doing what only they can do?

And then the next level down, can we make sure they're doing only what they can do, et cetera, so that we're maximizing the capacities of the workforce that are out there. And I think the quick answer is, no, we don't really do it that way very well yet.

But anyway, I think Paolo and then over here to Chris.

MR. PAOLO DEL VECCHIO: Just to build on your comments about the peer workforce, and we talked earlier about those who have a mission as well as the need for extenders for services, and what better than peers? Over the last 10 years, the explosion that we've really seen in peer specialists and recovery coaches around the country, where we see peers working in so many settings at this point.

And a lot of it's coming from Georgia, I have to acknowledge. But now we see the vast majority, only a few States not having Medicaid-funded peer specialist programs. When we see, if you look at the triple aim that healthcare reform is about -- efficiency, effectiveness, consumer satisfaction. And again, we have data around the use of peers effective in all those areas.

What's really exciting as well is the expansion in addictions in youth, in family peer support providers, but we also are looking at we've developed almost -- as this has developed so quickly, how do we get standardization across the country to make sure people have at least a basic level of skills and competencies as they go forward? And then on top of that, the financing, particularly in a healthcare reform context. We're doing work in these areas.

And then comes in the aspect of working within integrated teams. And so, the

need for training for other treatment providers on the use of peers. One thing, Chris, certainly in the VA, again another area where with the Executive Order, 800 peer specialists in the VA being hired right now.

And then the data piece as well, Pete. The kind of data we have around peer specialists and recovery coaches is so minimal, and the real need to begin to collect data on that workforce is huge. That's just a few of the issues we're facing.

MS. PAMELA S. HYDE: And this may go to a good place, although I want to get you guys to say what you had on your minds, but this may be a good place to talk about SAMHSA's role because there's a jillion things that may be needed in workforce, and we just can't do them all. And so, we have sort of carved out that perhaps an area that we could add to is this peer issues, and Paolo phrased them very well. So I'd like your reaction to that, too, or if you think there are other things we ought to be paying attention to.

Yes?

MR. CHRISTOPHER R. WILKINS: Chris Wilkins.

That's kind of where I wanted to head. Eight hundred peers in the VA, 5,000 more mental health professionals being hired in the VA as we speak. And all the data -- thank you, Linda, very much -- that you put forth, all of you put forth.

We have been operating in a culture of scarcity so long we very, as pragmatic people, default to what are the efficiencies we can build? Where are the career ladders? How do we extend with peers? How do we extend with telepsychiatry? How do we build greater efficiency and effectiveness? And we do that for a natural reason. That's what's attainable. That's what's reachable.

But I really think that health system leaderships and policy leadership understands that if the cost curve is going to truly bend, that they're going to run into mental health and substance abuse in a big way. And I think that creates the kind of advocacy opening in the Now is the Time mentality for SAMHSA to prioritize a big, bold initiative on workforce with all of its component parts. The tactics that we're used to, right, the pragmatic tactics, but also something that finally brings into the light of day and to legitimacy the power, the strength, the efficacy, and the competency of our workforce. Right?

I really believe that there is a definable policy ask to make sure that we've got the people we need because, look, we can take a smart car in the Indianapolis 500 and turbocharge it and put bigger wheels on it, and do all the things that we want to do, but to win the race, we've got to be driving an Indy car. And we've got as much right to drive one as anybody else in healthcare.

The nurses sold the healthcare system on their legitimacy, their competency, their efficacy, and their value proposition. We can do the same as a policy matter.

MS. PAMELA S. HYDE: I keep saying this, but I've lived long enough now to see some patterns. And one of the patterns we saw 20, 30 years ago -- and help me, Marleen, with the time -- was the lack of teachers. And we may still have a lack of teachers, but there was a real shift over almost a generation where it was clear teachers were needed, and more young people started going into that field. And I'm sure it's still an issue, but it made a shift.

The same thing was true of nurses. I can remember when nurses were paid $20,000. You get $60,000 plus a bonus to go into some of the hospital systems these days, and I think there was a shift in that. So there is something about demand creating supply. So there's some of that.

There is also I think the issue you're raising is what -- there's also going to be a shift in the workforce, I think. I don't think it's all going to be psychiatrists, psychologists, social workers. I think primary care physicians are increasingly doing behavioral health issues. They already were in terms of prescribing.

But especially like in FQHCs to the extent they're being trained and they're being held accountable to doing certain kinds of screening and early intervention around these things. So I think there is kind of this shift that's going on or is going to go on in the workforce as people understand that I think we're getting the message across. The problem is we're getting the message across. Behavioral health is essential to health. And if they want these things to work, if they want these systems to work, they're going to have to.

MR. CHRISTOPHER R. WILKINS: Yes, and so SAMHSA has to lead. They have to be recognized as the leader in that discussion. As nurses are already poaching like mad into our stuff, and if you need people and they're competent and they can do it, that's a good thing, I guess. But it is appropriate that this agency -- you've set the table. You understand the problem best, and you can lead this conversation.

MS. PAMELA S. HYDE: One of the ways we are trying to define leadership because we haven't -- we're struggling through this as a leadership team, is leadership isn't always us doing it. Because in this case, HRSA is the leader on manufacturing workforce, to use that term. So we're not the ones that are going to manufacture workforce, and they're huge partners with us.

It's just like we're not the payer of behavioral health services. Medicaid and Medicare are. Veterans Administration are. So part of our struggle around our leadership role is how do we lead without always doing everything? And what leadership looks like in this arena is part of what we're struggling with. So thanks

for that comment, Chris, because that's exactly where our heads are is what do we do about this?

DR. MARLEEN WONG: Well, if, in fact, we are moving in the direction of more peer-led interventions, I think it would be extremely helpful to know, to have a discussion about what are the standards? What are good training programs? What is the role of a peer sort of provider? And what kind of certification process?

Because in California, there is -- Medicaid does pay for sort of nonlicensed peer interventions. But it is within the team context. So it's more case management and from the traditional kind of social work approach. But I can see where if this large number of people are moving in, certainly peer interventions have been accepted in gang-related issues. So I'm sure there will be a growth also in substance abuse.

DR. STEPHANIE M. LE MELLE: Stephanie Le Melle.

As we're talking about this, the thing that's coming to mind for me is really the concept of a multidisciplinary team, what does that mean? And I think that peers can be part of the multidisciplinary team. Nurses can be part of that. Psychologists, social workers, the whole gamut are part of it. But none of these disciplines or groups are taught how to be part of a multidisciplinary team, and there's a certain need for management thinking, right?

Because you can throw a bunch of clinicians and trained people into a room, but they're not going to interact in an efficient or effective way unless they know how. And maybe that's something that SAMHSA could really think about is how do we come up with training programs that can be used, as they say, while the train is moving because we're going to have to do this in place. I mean, we'll do it with trainees that are coming up the pipeline, but we've got to do it in place.

How can we train people to think about themselves as a multidisciplinary team, what their role is within that team, and then how do they act -- again, I use the term "boundary spanners" -- to reach the other team members? Because each one of these people is bringing something unique to the care of the individual. But we never teach clinicians how to do that. We tell them they have to do it, but we don't teach them how.

And I think using these new concepts, and there is some data on this now, teaching systems-based practices, and what do we really mean by systems-based practices? The role of the individual one-on-one relationship. Being a team member, what does that mean? Information integration, how do you share information with your other team members, and then how do you manage resources and not only just the resources of the system of care that you're working in, the clinic or whatever, but understanding the patient's resources.

What are their resource needs?

Because they never match, right? What we provide to people and what they really need never match. But how do you manage it efficiently to make it work? But we don't teach that, and I think that that could be something that SAMHSA could really spend some time thinking about is how do you design a real functional and efficient multidisciplinary team?

And I'm sorry. One last thing about peers in particular. We never teach clinicians about how to work with peers. We teach peers how to work with clinicians, but we never teach clinicians how to work with peers. And there have been a few good studies on that as well that I think have not been replicated and are not being used.

MS. CASSANDRA PRICE: Well, this is Cassandra Price.

I think that is true, typically. In Georgia, what we've done is when we do the certification process for the peers, we actually have a track for the supervisor of the peer to come in and we really delineate about what that looks like and what the peer role is. And then we also plan on doing some of the faces and voices principles around that and doing some statewide training for all providers.

So it's not just about the person potentially supervising the peer or working with the peer, but it's a broader-based context. But I think that's an excellent point that we throw peers sometimes into situations where their role is very misunderstood, and they're asked to do things that aren't really a part of what they're there to do. And it's critical that the entire system is recovery oriented so they understand the role of peers.

MS. FRANCES M. HARDING: I just wanted to give some hope.

MS. PAMELA S. HYDE: That voice is Fran.

MS. FRANCES M. HARDING: Sorry. Fran from CSAP. I know. I'm terrible at it. You were supposed to help me.

The multidisciplinary teams and working with peers, go to your prevention programs. They've been doing this for years. Now it's not perfect because they haven't been doing it in the area of clinicians, but they've grown up with -- we started with a group of volunteers across the country. Then they became trained, and they work with volunteers still all the time. They work with people with lived experience.

We have people from all disciplines. In schools, that's where you need to go are your in-school interdisciplinary teams because the school systems around substance abuse, and I suspect now mental health, they have their criminal

justice, parents, members of the school board all working together to do that. They do their training, and so we don't have to start from scratch.

So as we're trying to beat the clock, which is what I kind of interpreted what you were trying to say, I think that we should look within ourselves to find where are the strengths and some of the skill sets that we need.

DR. H. WESTLEY CLARK: And consistent with what Fran is saying, when we look at household survey data -- this is Wes Clark -- the largest number of people perceive no need for treatment for both mental health and substance abuse, which means that while they're meeting criteria, they're still functioning. And that then gives us an opportunity for early intervention, and so we're dealing with risky situations as opposed to full-blown situations that demand immediate interaction.

So coming up with this continuum actually makes a lot of sense, where you've got individuals who can spot colleagues who are -- or classmates who are having problems and say, hey, people in recovery or people who are knowledgeable about some of the early signs of dysfunction who are able to align that person with early help. So you don't necessarily need a psychiatrist or Ph.D. psychologist, et cetera, but you're beginning to deal with either the substance use symptoms or psychologist symptoms that would suggest a more complicated problem.

So the data do show that the people perceive no need. It's not that they don't want treatment or they get treatment and can't get it. It's that they perceive no need for treatment. So they must be functioning well enough not to believe that treatment is indicated. So this does offer us a tremendous opportunity to promote this full continuum of associated interveners, if you will.

DR. BENJAMIN SPRINGGATE: Ben Springgate.

I agree with the opportunity presented by the use of peers. In some of the work that I did a few years ago, we developed a community health worker training institute in south Louisiana. And the challenges that many of the organizations that wanted to hire these community health workers to do even mental health work, and some of our trainings were specifically focused on that and they were interested in working in those areas, was there was no reimbursement opportunity for that.

And so, as we see healthcare reform and the ACA moving forward, part of what I heard Paolo mention was exactly that, that, A, there need to be opportunities for reimbursement for some of these fields for people to go into work there, and then the other question was nationally, community health workers, even amongst as a profession, as one example profession, have a debate amongst themselves what level of standardization do we want to have?

Some of the historic underpinnings for some of these groups that have developed in different communities is we came out of the needs that were identified in our specific communities for our peers and our circumstances. And your standardization from elsewhere doesn't necessarily meet with the practice-based evidence or our own experience that we're trying to build with and treat people with and help our community with here.

MS. PAMELA S. HYDE: So can we just wrap this up by going back to what I think Chris was really challenging us about -- and as I said, we're struggling with this -- is what role does SAMHSA play, given the other players, given that increasingly CMS is setting the guidelines for what's going to get funded or not, and we work heavily with them around that. Increasingly, HRSA, and they've really taken on this issue of increasing behavioral health out of their National Health Service Corps as well as their FQHCs.

And then we have -- we are the leaders in terms of the budget proposal around workforce. Even though some of it is going to be done by HRSA, it's going to come to SAMHSA because the theory is that it will be coadministered and that SAMHSA does have a leadership role around that, but a significant portion of it is going to use HRSA's authority. Because we have both authority problems and appropriation problems. We have to have both.

So there is that sort of swirling issue, and then this conversation about peers and the role that we may play in that. So any final comments about SAMHSA's role in this?

MS. CASSANDRA PRICE: This is Cassandra Price.

One thing that I think Paolo said that struck me, when you said efficiency, effectiveness, and consumer satisfaction, which were kind of the guidelines or driving force around healthcare reform. So I was sitting here thinking, well, the new title SAMHSA promotes the phrase you used that I didn't write down.

So if you looked at SAMHSA from a global perspective, and you put everything under those three guidelines related to behavioral health, how does that shake out for SAMHSA? So, for effectiveness, what are the policies to make behavioral health effective across the system? What evidence-based practices? And then for efficiencies, how do you use discretionary grants or your grant portfolio to have effectiveness across a behavioral health system? And consumer satisfaction, your barometers and your quality framework.

And so, I was just trying to figure out how you fit it into a piece that feeds in up to the big, global healthcare and wellness reform, and where does behavioral health kind of carve out into that? So that was my little momentary disassociation of one comment, and I went somewhere for a while.

It happens. Sort of, kind of happens.

MS. PAMELA S. HYDE: That's great.

MR. CHRISTOPHER R. WILKINS: Chris Wilkins.

Since I popped off with the challenge, maybe four concrete things. One, establish an MOU with HRSA capitalizing on their financial and rate-setting leverage, whereby you define SAMHSA as the content expert on definition of the behavioral health workforce problem. Check, you've done it, right?

Second, you define the short-term tactics that I think you have consensus on around the table about diversifying the workforce with all of the tactics that we discussed in this discussion.

Third, that you define a longer-term set of tactics on building the workforce beyond the attainable short-term tactics to more robust training, competency, interdisciplinary collaboration.

And then, fourth, that you become the content experts on setting up the measures for what a newly deployed, effective workforce looks like in the ACA. That would be four things I can think of.

MS. PAMELA S. HYDE: I heard another task for Pete in there.

[Laughter.]

MR. CHRISTOPHER R. WILKINS: Hey, Pete. You're welcome.

DR. PETER J. DELANY: You're really enjoying that, aren't you?

MS. PAMELA S. HYDE: All right. That's really helpful. So anything else that anyone wants to add here to this conversation? Charlie?

MR. CHARLES OLSON: This is Charles.

I'd just like to add this story just because of the relevancy. But just it was literally just last week that a friend of mine called because her 92-year-old psychiatrist was forced into retirement, and she had realized that her prescriptions were coming to an end. And the next appointment was 6 weeks out, and they couldn't schedule her in earlier because that's how far out it is. And it took a disturbing amount of advocacy to get her that slip of paper to get her meds refilled.

And so, it's both exciting and frightening to me to know that there's 11 million more people joining that. So I'm glad to see that this is coming up at the same

time.

Thank you.

MS. PAMELA S. HYDE: Well spoken. Thank you.

All right. Well, thank you, Linda and Miriam and everybody else who's been working on this issue. And Paolo is leading some of the stuff. You're getting a flavor of what we spend our angst on, Chris.

All right. So we're going to move to prescription drug abuse. I think in this area, this is another one of those areas where we are by far not the only players. Medicaid and Medicare, because to the extent that prescription drug abuse is an issue, it doesn't only happen around pain medications, but that's a heavy place where it operates. And obviously, with an aging population, a population with disabilities, and a population that has chronic health conditions, pain medication is a big deal.

So CMS in both its Medicaid and Medicare arms are as concerned about getting people access to pain medication as they are about making sure it's not abused. So those issues, we have obviously SAMHSA and HRSA and IHS that provides direct care to Native American populations, just a number of other -- FDA has a major role in this arena. So there's a lot -- and NIDA and NIAAA and NIMH, all of them have big issues to play here, as does the Surgeon General. So there's a lot of players in this ballpark.

And Fran is going to talk a little bit about what's going on and what we're doing about that.

Agenda Item: Prescription Drug Abuse

MS. FRANCES M. HARDING: Thank you.

MS. PAMELA S. HYDE: I think Wes is going to help.

MS. FRANCES M. HARDING: I was just going to say that. There was my introduction. Fran Harding from CSAP.

We thank -- Wes and I thank you. Dr. Clark and I are going to take you through about 20 minutes each of our information from prevention through treatment of what SAMHSA is doing for prescription drug misuse, and then we're leaving quite a lot of time left over for some questions and conversations. Hopefully, that's what Dr. Clark agreed to because that's what I told -- sometimes we're told what we're agreeing to. So I just want to make sure. Told by our secretaries

most of the time.

So I was told there were some new people. Oops, wrong one. Here. So we're starting with the beginning of how this -- how prescription drugs actually fits into SAMHSA's vision, and I know you said it was slow.

The middle button? The left one? Oh, not that slow. I was slow. Sorry about that. I'll pick up.

So, basically, we've been talking about this. You know the vision. I think Chris has memorized it. You can become part of our team, if you'd like, Chris? You know the Finger Lakes aren't all that attractive. We have the Potomac.

One of the things that I wanted just to make sure everybody was on the same page for, especially some of our newer NAC folk, are the strategic initiatives. We do a lot of talking about the initiatives. But as you heard yesterday from Pam, the three initiatives are in the Secretary's -- we overlap -- prevention, trauma and justice, and health reform. We have separated these up into the three major aims for the Secretary's Department of Human Services strategic plan. Improve the Nation's behavioral health, transform healthcare in America, and achieve excellence in operations.

So you can see where those strategic initiatives fit in each one of those initiatives. So where does prescription drug prevention programming actually fit? And it fits into the strategic initiative number one, where we promote emotional health and we reduce the likelihood of mental illness, substance abuse, including tobacco and suicide.

When we achieve these goals, we -- which, of course, we have a year and a half left, we will have reduced the likelihood of suicide and mental illness and substance abuse in the country, at least we have a very good beginning of doing that.

The strategic initiative one actually has three main or four main goals. First goal is to talk about emotional health. As Pam said, the strategic initiative one overlaps all of the prevention programming in SAMHSA, which is our behavioral health portfolio, which is substance abuse and mental health programming.

Goal number two addresses underage drinking and adult problem drinking. We will continue to focus on underage drinking because we just don't seem to be able to get ahead of this problem in our country. Country people tend to savor their alcohol, and the habits and conditions and norms across the country in many of our communities have not changed.

As Pam has mentioned a number of times, we have yet to figure out is it the fact that we don't have enough prevention programming? Do we have the prevention

programming in the wrong areas? Or are we doing the wrong thing? I would say that it's not the latter.

I'm sorry. I'm not going to attempt to go back. The other goal number three is suicide. Preventing suicide and suicidal attempts in our population.

And number four focuses on the misuse and abuse of prescription drugs.

I said I wasn't going to do that. We have NSDUH data that supports the use in the last 10 years, 22 million Americans began using prescription drugs for nonmedical use. However, there are some good news. The good news is in the 18 to 25 population, there has been a slight decrease.

Now I just got back from the prescription drug summit, the second national summit on prescription drug abuse, and the Centers for Disease Control has declared prescription drug abuse an epidemic in our country. Our NSDUH data does not necessarily support an epidemic, but we sure agree that it's a growing and pervasive problem.

Sorry. We had some issues here, but I'll just keep on going. So another challenge we've -- excuse me. Great. That one is fine.

One of our target populations is prevention's larger role. Another challenge we face is the need to educate parents, who may not be aware. Parents really are right now in the prevention arena around prescription drug misuse are our major target, believe it or not. For a couple of reasons. One, we can achieve outcomes with parents. Two, parents not only are the target because of their role as the parent of young people, but also as the role of setting examples of use of prescription drugs for our young people in America.

According to the National Poll on Children's Health, which is administrated by the University of Michigan's Mott Children's Hospital survey, we found these statistics to be pretty interesting and telling and helps really well to start a conversation in communities around prescription drug misuse and a parental role. Only 35 percent of parents were concerned about the misuse of narcotic pain medicines by their children and teens. That's a pretty high number.

Only 19 percent were very concerned about the misuse of medicines in their own family. Forty-one percent of parents said they favor a policy that would require a doctor's visit to obtain a refill for medications. I found that to be interesting because that's a little bit higher than I would have expected. However, approximately 50 percent do not favor a requirement that unused pain medicines be returned to a doctor or pharmacy.

We're dealing with a real cultural situation of how we use prescription drugs. Sixty-six percent of respondents strongly supported requiring parents to show

identification when picking up narcotic pain medication for their children, and 57 percent strongly supports policies blocking narcotic pain medication prescriptions from more than one doctor. That's very consistent with some of the programs that Dr. Clark will be talking about.

The National Prescription Drug Abuse Prevention Strategy employs a multifaceted approach. So what are we doing? We're educating an awareness of prescribers for consumers on dangers of the prescription misuse. We're designing, implementing, and the enforcement of State prescription drug monitoring programs, which Dr. Clark is going to discuss in detail.

Proper storage and disposal of prescription drugs. Can't tell you how many parents that we've run into across the country who never have given it any thought of where they put their unused prescription drugs, and the target that we're seeing that it's not their children, it's the babysitters that come into the home that are availing themselves. It's eye opening. Simple messages. Important outcomes.

Enforcement tools to eliminate improper prescription drug practices like stop pill mills. Again, Dr. Clark will be getting more into this. We're working with several partners across the country on different levels.

Obviously, here in SAMHSA, we work with Pete. We work with Dr. Clark and several of our offices. We have the Behavioral health Coordinating Committee. We brought that up earlier on another issue, where it's chaired by Dr. Howard Koh and our own Pam Hyde. It is a collection of all of the agencies from Health and Human Services, and there are five subcommittees. One of those subcommittees is on prescription drug misuse.

We work with ONDCP, the DEA, Education, Justice, and the Indian Health Services Center. We also work with several communities, communities and States, particularly some of their government groups.

All of SAMHSA's efforts align with the national priorities in collaboration with several of other Federal agencies that SAMHSA works with, as I mentioned. Prescriber and consumer education is our number-one priority. Prevention of prescription drug abuse in the workplace is another one.

State program support, SAMHSA's Partnership for Success grants where we just released back in March 29th. The applications are due on May 17th, and in there, we have two priorities for States to look at, and the priorities were chosen because across the country, the data supported the two major problems in the States at the time were underage drinking and prescription drug misuse.

So for the first time, we put in these restrictions where most of the grants that came out for prevention in SAMHSA lets States choose their own from a variety.

This was our attempt to try to focus our efforts and our dollars into the areas of most concern.

Now because a State and a territory are not the same, we also put in the fact that if your State data show that you had another problem, either another drug, like marijuana or methamphetamine, you could substitute either underage drinking or prescription drug and add in that third component. You could probably have come in for all three, but we discouraged that because of the data, the effort that it would take to be able to do that.

Promotion and safe means of disposal. I said that we worked with the DEA for -- we work across the -- we help the DEA spread the word of their disposal campaign. For example, SAMHSA helps to promote the Drug Enforcement Administration's Next Take Back initiative, which we always promise that we advertise as much as possible. This is year, it is April 27th.

Now, on April 26th -- you might have known about the 27th. You don't know about the 26th. April 26th is the Federal take back day. DEA works with all the Federal agencies across mostly the D.C. area, and we collect tons of prescription drugs on that day as well.

We also work with our State partners, NASADAD particularly. We are getting better at working with NASMHPD, not as -- the structures are different. So it's just taking us a little bit more time. It gives you some stats up there to show that with 34 States, 11 of those saying it's most -- prescription drug misuse is the most important issue that they face. It shows you why prescription drugs is growing and is seen as an important issue.

SAMHSA is holding its second National Prevention Week. We haven't really talked about this much. In the back, there is a calendar of events. This year, on May 14th, the whole week, that whole day rather is devoted to prescription drug misuse. What the prevention -- it's our second annual Prevention Week. It's just taking off. Our new communication director has really begun to put a face on this week, and it's important. So we're looking at tobacco, underage drinking, prescription drugs, alcohol, suicide, and then the last on that Friday, May 17th, promotion of emotional wellness is our shorthand of talking about it.

This year's theme for the entire week is "Your voice. Your choice. Make a difference." I recommend that you go onto our Web site, and you will see Pam and Kana and several of our leaders holding up that poster that you see up there on the corner of the room saying what they choose rather than alcohol and other substances.

So now I'm going to take it away from this quick review of prevention and give it to Dr. Clark to be able to talk to you about in more detail the clinical pieces in the programs that we fund.

DR. H. WESTLEY CLARK: Thank you, Fran. And appreciate your --

I'm going to talk about the Center for Substance Abuse Treatment initially in terms of what it is that we've been doing in this arena in part because for quite some time, we have been actively involved in the area of regulatory oversight of opioid treatment programs, working replacing the Food and Drug Administration in this area.

So it's important because it is through that experience that we became painfully aware that prescription opioids were being misused, and the data that CBHSQ highlighted through NSDUH confirmed this. So, right now, we support, certify, and accredit 1,250 opioid treatment programs that treat over 300,000 patients annually, and that provides us with an in-clinic, if you will, source of information about what's happening with people.

We also with the DEA implement the Drug Addiction Treatment Act of 2000, which allows medication-assisted opioid addiction treatment in physician's outpatient offices so that it allows physicians to prescribe Schedule III, IV, and V narcotic medications for the treatment of opioid addiction in outpatient treatment settings other than in traditional opioid treatment programs.

And then, consistent with that, we support the training of medical and substance abuse professionals on a variety of treatment issues, including the use of these medications, particularly with a focus on buprenorphine. So our prescription drug activities are listed up there, which include opioid treatment programs -- and I've very, very briefly given you what we do with methadone and buprenorphine -- prescription drug monitoring programs, and medical education.

So this now moves from -- our experience moved from the experience in opioid treatment programs to the larger arena as we became aware of the problem. I'd like to mention the buprenorphine issue shortly.

Our role in the treatment of methadone, we have the authority to regulate the use of the methadone in treatment, and we're responsible for the day-to-day management and oversight of the regulation. So we've got OTPs in 45 States, D.C., and Puerto Rico and the Virgin Islands. So with these individuals who are in treatment, we became concerned about issues like HIV, hepatitis C, and psychiatric comorbidity.

Again, many of these individuals are being seen on either a daily basis or weekly basis. So they have a lot of contact with the healthcare providers and the counselors, the physicians, the nurses, and counselors and pharmacists. So we gain a lot of clinical information about them.

So methadone, combined with medical and psychosocial services, has been

demonstrated over time to be an effective treatment for chronic opioid addiction. And in addition to opioid and the medical issues like hepatitis and HIV, many of the individuals also have co-occurring psychiatric conditions which are being treated or at least being monitored in the OTP programming.

Since 2000 and data in 2000 being in effect, we've been responsible for this. So physicians have got to meet the requirements of the law. So either they have been certified or they have to have no less than 8 hours of training provided by a medical organization such as the American Psychiatric Association or the American Association of -- the American Society of Addiction Medicine. And so far, buprenorphine is the only FDA-approved medication that's prescribed for this purpose.

And the important part of that is that the buprenorphine is dispensed, is prescribed in the physician's office. And one of the things that we discovered that had a lot of practitioners, even though it only requires 8 hours of training, are reluctant to prescribe buprenorphine.

So whenever I meet with a primary care doctor, "Oh, how many of you prescribe Dilaudid or codeine or a medication like that?" All the hands go up. "How many of you prescribe buprenorphine?" Very few hands go up.

And I said, "Oh, so you're part of the problem, but not the solution. Is that it?"

[Laughter.]

DR. H. WESTLEY CLARK: Hey, I get to say that.

MS. PAMELA S. HYDE: He gets to say that because he is a doc, see?

DR. H. WESTLEY CLARK: So, anyway, 90 percent of OTPs are privately operated, and the majority are private-for-profit, which is an issue. And there's a paradox in that issue. North Dakota, South Dakota, and Wyoming do not license OTP services. But the private -- some programs are discovering that they don't want Medicaid funding. They don't want insurance funding. They are only out of pocket because people are protecting their own privacy.

So that creates a dual system. People with resources can go to a private OTP and not disclose who they are. Because even under HIPAA, the HIPAA modifications of 2009, 2008-2009, if you pay out of pocket, nobody can disclose any information about you, if you don't want them to. So third-party payers can't get that information because you're paying out of pocket, and it's in the law.

So these are issues associated with that, and we do have some concerns about that. And the fact, but because we regulate these entities, we are able to address that.

Now with regard to prescription drugs, the prescription drug monitoring programs is what a lot of people here probably want to hear about because what we're trying to do is to allow practitioners, and we're not the inventors of PDMPs. In fact, they evolved over time. There used to be triplicates, and the doctors would sign a form and give you one prescription and have a carbon copy of it. Stephanie or Ben, you might recall that.

The problem with that is then you wind up having a bunch of pieces of paper. Even the State wound up having a bunch of pieces of paper, which they can never sort through. I mean, it was a joke. I mean, you really had to be a bad physician for anybody be picked up, and then usually they'd send somebody in as a decoy.

So PDMPs, once electronic health records, once the electronic capability came, these weren't attached to EHRs. Once the electronic capability surfaced, healthcare providers could access online the scheduled drug prescription. So PDMPs were able to collect, monitor, and analyze electronically transmitted prescribing and dispensing data, and the data then were used to support the State's efforts at education, research, and enforcement, and abuse prevention.

PDMPs are managed under the auspices of State, Commonwealth of the United States, and these are the jurisdictions that had various PDMP programs. Missouri was the only jurisdiction that did not have a PDMP, and it's my understanding they now have legislation pending. Iowa has been trying to enhance their PDMPs because they wanted to make it more effective. The problem with the PDMPs was that they are standalone.

They operate outside of the medical record. The problem with that is sometimes it would take 2 weeks before you figured out that the patient who you had written a prescription for 2 weeks earlier had 5 prescriptions from 5 different practitioners, which then rendered the PDMP kind of impractical. Oh, you've been ripped off. Well, thanks for letting me know 2 weeks later.

So we've been collaborating with the Office of the National Coordinated Health Information Technology, ONC, on two pilot programs in Indiana and Ohio, collecting PDMP databases to electronic health record systems. So, as you know, there's a tremendous push to have the healthcare delivery system adopt electronic health records. Some of you may have gotten meaningful use incentives as a result of that.

So we found that you can, in fact, marry the electronic health record with a PDMP program. Indiana, 32 percent of their 38,000 physicians eligible to participate in the system were registered users of it, accessing the data an average 5,000 times per week. We can get to doctors because one of the things that you realized was that, suddenly, you could get this information a lot sooner

and a lot more practically than the older PDMP, the siloed PDMP, the PDMP that only got the information from the pharmacy, which then took 2 weeks.

Ohio, the Springfield Center for Family Medicine is testing the effectiveness of having a drug risk indicator sent to EHRs to primary care physicians. This program would send an alert to a physician's EHR if a risk is identified. So people talk about what should be the standard of care? How much medication should you prescribe? What we're trying to do with this process is link the practitioner with the PDMP.

SAMHSA's PDMP and EHR integration and interoperability cooperative agreement specifically supports our eight strategic initiatives. That's prevention of substance abuse and mental illness and health information technology, and they address the requirements for increased interoperability and integration as a part of health reform.

The launch of the project in 2011 --

MS. PAMELA S. HYDE: We're going to run out of time for comment if we can -- because I know you've got other things to present, Wes. So if you can get through this, that would be good.

DR. H. WESTLEY CLARK: All right. So, basically, let me march through this. This is the cartoon of how we put the pilots together to improve clinician workflow by connecting the PDMPs to HIT, to support timely decision-making, and to establish standards facilitating information exchange. It's in your handout. So I won't dwell on it. Now we're caught by the catch in the system.

These are jurisdictions where we've got pilots. I won't go through them. These are the summary of the pilots. As you can see, we're working with multiple end-users, and we've got a PDMP resource center that is going to be housed at ONC's health IT connect. So we are -- we also have a PDMP standards and interoperability framework, and we've presented this information.

We're facilitating medical education, and I won't dwell on the specifics. So we want to make sure that practitioners know something about prescribing controlled substances, training of health practitioners, including physicians, dentists, nurse practitioners, oral surgeons, and others, including psychologists in those jurisdictions where they prescribe. And we're collaborating with State boards of -- medical boards.

These are jurisdictions where we've had courses. As you can see, we're trying to reach as many jurisdictions as we can. We also have a course that the State of Massachusetts sponsored. It's an online course. Course contents, best practices, evidence-based strategies, techniques for effective patient monitoring, the risk and benefits, and then 76 percent of the physicians in a follow-up survey

said that they made changes.

The key issue, though, for all practicing practitioners is there's been enhanced scrutiny. With the PDMPs and EHRs, it behooves practitioners to pay close attention to this.

DR. STEPHANIE M. LE MELLE: I know you don't have time, but I just wanted to add in a discussion we had yesterday, it came to my attention that veterinary doctors need to be included in this as well.

DR. H. WESTLEY CLARK: Yes, that was an important point. We make sure that veterinary doctors -- we should make sure that veterinarian doctors are aware that Fido and Kitty, while they may not abuse the drugs, the vets themselves or their technicians may abuse the drugs. Or their kids. That's true.

So, anyway, there are multiple modules in the training programs, opioidprescribing.com. I won't dwell on that. As you can see, we have this information. Safe and effective opioid prescribing for chronic pain. We have a grant program that is supporting opioid therapies, the focus is on the safe use of opioids.

And one innovation that one of our grantees developed was a safe opioids iPhone application so that people can use that, and then these support systems are sort of warm lines. If you have some concerns, you can call, and someone will talk to you about sort of giving you a second opinion about your strategy.

And the key issue is, as Pam pointed out, we're not trying to keep people from being treated for pain. On the other hand, we want to make sure that practitioners are aware that they have a special obligation.

So the training programs, we're getting a lot of satisfaction for those. We also have a buprenorphine training module. Again, it's done by the professional organizations so that practitioners are getting guidelines from people in the field who are like themselves in practice, but who have established bodies of knowledge and experience. We've got treatment improvement protocols on detoxification, medication assisted, and managing chronic pain in adults who are in recovery from substance use disorder.

We've promulgated advisories on prescription misuse -- Oxycontin, methadone, and Opana abuse, oxymorphone, which is another drug.

So, thank you. We are working with our colleagues at DEA, FDA, NIH, particularly NIDA, and HRSA so that we can achieve this. And then CMS, I also need to mention CMS, as well as ASPE.

CMS did a study. They thought they were going to -- a Part D study. So they

thought they were going to come up with a very clean and elegant, hard and fast approach. They discovered, to their chagrin, that even when you had people who were using a lot of opioids, it wasn't necessarily about abuse. So that was why you need to approach this on a case-by-case basis and need to approach it carefully.

Sometimes it was simply that the doctors weren't cooperating, and people would go someplace else to get adequate management, and it turns out that that's an issue also.

Thank you.

MS. PAMELA S. HYDE: So before we jump into conversation about this, let me just add to what Wes said at the end there. The Secretary got very interested in this issue personally a year or so ago when -- I think she was always interested in it as an issue. But then, frankly, Medicare, the head of Medicare got really kind of raked over the coals at a public hearing before Congress about Medicare, prescribing in Medicare. And so, she asked a lot of people, including us in the BHCC subcommittee and then ASPE, to do a variety of things, one of which was put together some recommendations for approaches across the whole department.

Because, again in Medicare where they're dealing with basically older and disabled individuals, making sure there's adequate access to pain medication is a big issue. And just because there's multiple prescribers doesn't mean -- or multiple prescriptions doesn't mean it's a bad thing. So they want to make sure they didn't undo that and at the same time look at all these other issues.

So ASPE has been leading for the last few months, and we're participating in that. And they've been doing an extensive data review of Medicaid and Medicare data, and then now they're going into private sector data looking at prescribing practices, looking at who's prescribing, who's getting them, who's refilling them, for what purposes, what's their diagnoses, et cetera. So there's a lot of work going on about that, and as they call it, as they peel back each layer of the onion, it gets just more complex rather than less complex about what to do about this.

And they briefed the Secretary recently. Some sort of the high-level places. So it's maybe the obvious, but there's a lot of data now behind it, one of which is to improve prescribing practices. So this is that issue of training and getting people to prescribe correctly. And they specifically said it that way because in some cases improving prescribing practices is to provide more, more or better medications rather than what they're doing.

Secondly, it's to prevent diversion. So this issue of fraudulently getting these medications and then getting them somewhere else, getting them on purpose.

Purposely getting them somewhere else. So diversion.

And then third area, I think, is misuse. So once you've got an appropriate medication and it's being appropriately used, but you're leaving it in your medicine cabinet or something else, and it's getting I guess you could call that diversion. But it's getting inappropriately used.

And sometimes that's not a person taking it and taking it on purpose to be high. We're seeing an increasing number -- and if Pete was here, he would be the first to tell you the data. We're seeing an increasing number of both deaths and hospital emergency room admissions because of misuse of prescription medications, not necessarily intentional misuse. But that's especially true, I think, in the older population.

So, anyway, lots going on there. So I think, Cassandra, you were on first.

MS. CASSANDRA PRICE: Cassandra Price.

I definitely have some interest. Georgia enacted legislation, and it just kind of stalled. And so, I'm not even sure where it's at. A lot of discussion about where it should be housed, how to fund it. And I'm talking about, of course, the PDMP.

And so, a couple questions. One, the resource center that you talked about here, when will this go live? And secondly, is there one State that you think has done it just absolutely right? They have that balance around what does the data show them, and these PDMPs -- I can never remember the acronym -- and the right place of where it's located. What agency is kind of the shepherd?

So those were my two questions.

DR. H. WESTLEY CLARK: Kentucky, Ohio, and Indiana are dealing with this, and they appear to have done it right, but because they're also interested in the regional aspect of it. You should be aware Georgia, let's say, over by Savannah. So I can drive up to South Carolina or drive down to Florida. So one of the things that Kentucky realized, given its similar situation, that people could just easily access other jurisdictions. It's not that big of a State so if I'm into misuse.

Florida, because of pill mills, as Fran pointed out, people would migrate to Florida just to buy a bunch of pills. And unfortunately, the medical profession wasn't always, we say, ethical. In fact, even in Virginia, they have a lawyer who hired a bunch of doctors whose sole purpose was to write prescriptions. So, no, seriously. So that turned out to be an issue.

So those three jurisdictions, and I could link you up with Kate Tipping, who was our liaison with ONC on the prescription drug monitoring programs. We can look at what jurisdictions meet your needs.

You also have to keep in mind sometimes a PDMP is lodged in the criminal justice system. I prefer the public health approach.

MS. CASSANDRA PRICE: I agree. That's why I wanted your opinion.

MS. PAMELA S. HYDE: Yes, there's lots of politics about where the money comes from and, therefore, what the PDMP is used for. Chris?

MR. CHRISTOPHER R. WILKINS: Chris Wilkins.

Thanks, Wes. Thanks, Fran.

Wes and Fran and Pam, it would be great if we could get HRSA to -- because if I say one more thing, Pete is going to hit me with a baseball bat when I walk out of here. It would be great if we could get HRSA to get the data on surgeries that can't be performed because of opiate dependency.

I had the good luck/bad luck of sitting next to the chief spine surgeon from Rochester General on a flight recently, and he just beat my head in. You know how people do that to you? "You know how many surgeries we can't do because of this opiate thing?"

And then the other thing that came up in that conversation, Fran, was training for allied health professionals or qualified health professionals to do bedside post-op prevention counseling on opiate use. And then, Wes, is it still after you get certified or you get your X number, you can only have 30 patients for the first year? Is that still going on?

DR. H. WESTLEY CLARK: Yes, first year, but you can get up to 100 patients, and people keep trying to appeal that. We're not so sure that needs to be changed. Remember, you only got about 20,000 doctors who have the X number, but there are over a half a million doctors who are prescribing.

So it gets back to the assertion. I don't have any problems contributing to the problem, but I don't want to be part of the solution.

MR. CHRISTOPHER R. WILKINS: I don't hear much grousing about the 100 anymore, but I do hear grousing about the 30 still.

DR. H. WESTLEY CLARK: Okay. But what I'm grousing about is that all you need is 8-hour training. I have to do 50 hours a year CME. Eight hours, which you can do online is not a problem. So what the problem seems to be a stigma and discrimination because, indeed, if I view it as a problem, I should get an X number because all I need is 8 lousy hours. That's two half days or one full day, and I can prescribe buprenorphine. That's why we set up these warm lines so

that practitioners could do it with a minimal variance.

So it's not the limit. What happens is you continue to stigmatize. As we've been talking about integration, we shouldn't be continuing to press the patient population into a small group of providers when we've got 500,000 providers who are out there who are writing the scripts themselves.

MR. CHRISTOPHER R. WILKINS: I appreciate your concern, but I've got to respectfully push back. Thirty is crazy. The guy is a physician. He's been trained. It ought to be 100 immediately. That's it. Because if he's got the willingness, let's incentivize him to get to work with 100 people.

DR. H. WESTLEY CLARK: Well, that's a view --

MR. CHRISTOPHER R. WILKINS: Yes, it's a view. I know.

DR. H. WESTLEY CLARK: -- and I hear you.

MR. CHRISTOPHER R. WILKINS: So, anyway, and then, Wes --

MS. PAMELA S. HYDE: They are advisers, Wes. They're advising us.

MR. CHRISTOPHER R. WILKINS: Last, but not least, I have to pay the joint commission two times to walk into the same unit to accredit us for, and this is a detox. I have to pay once to have them accredit what we do with methadone for detox, and then they've got to come back in a second time for the alcohol charts, right? So two times, two fees.

And when I grouse --

MS. PAMELA S. HYDE: Is that something the Feds are doing or something accreditation is?

MR. CHRISTOPHER R. WILKINS: When I grouse about this, they say it's a SAMHSA requirement.

MS. PAMELA S. HYDE: That we go in twice? That we require them to go in twice?

MR. CHRISTOPHER R. WILKINS: Correct. They cannot certify -- or I'm sorry. They cannot accredit with one visit the whole unit. They've got to do it twice if you have an OTP certification. So we --

MS. PAMELA S. HYDE: Is that true, Wes?

DR. H. WESTLEY CLARK: Ah.

MR. CHRISTOPHER R. WILKINS: Well, I can tell you I paid the fee twice.

MS. PAMELA S. HYDE: Now whether or not joint commission is asking you to pay the fee, I'm not challenging that.

MR. CHRISTOPHER R. WILKINS: And then we had to do two reviews.

MS. PAMELA S. HYDE: What I'm asking is SAMHSA requiring a second review, or are they asking you to do two reviews, and they'll get paid twice?

DR. H. WESTLEY CLARK: I'll have to look at our guidelines.

MR. CHRISTOPHER R. WILKINS: I'll give you the name and number of the medical officer.

DR. H. WESTLEY CLARK: I'd appreciate that. So then we can have that discussion because that seems to be, shall we say, an encumbrance.

MR. CHRISTOPHER R. WILKINS: Yes.

MS. PAMELA S. HYDE: I mean, sometimes these are our regs or rules, and we don't realize the interplay they are. And sometimes the bodies that have to implement them are making choices to do things that gets them two fees. That may or may not be what they're required to do.

MR. CHRISTOPHER R. WILKINS: I just wanted you to know when I yell, they blame you.

MS. PAMELA S. HYDE: Yes, yes. Well, that's okay. We're used to being blamed. We just want to make sure that --

MR. CHRISTOPHER R. WILKINS: Not you personally, Pam, but the agency.

MS. PAMELA S. HYDE: It's all right.

DR. H. WESTLEY CLARK: Well, if that is being -- bring that yelling here is that we can look at it and see if --

MS. PAMELA S. HYDE: That's helpful, though. We really will look into that because that doesn't make any sense to me.

MS. CASSANDRA PRICE: This is Cassandra Price.

And off this topic, no, it's not off prescription drug abuse. But one thing that occurs to me that's a little bit different when we talk about prescribing practices,

and we talk about pain management options and how we have a lot of people really trying to delineate between use and abuse in the people who have chronic pain. There's a lot of alternatives around pain management that I think sometimes with the integration of primary health that really we need to make sure we're all educated on.

I go to a pain clinic for muscle spasms, and I have a Baclofen pump, which was the best thing that ever happened to me. So I don't have to take drugs that go through my bloodstream and impair me, make me all falling out. So I think that -- and there's also meditation and all these other great things out there that are options besides just prescriptions that lead to that abuse and use and dependence. So I just think that with integration comes those opportunities to educate multiple systems about options.

MS. PAMELA S. HYDE: I'm also struck by the physicians who are telling you they can't do surgery, which may very well be true. I probably once every other week get either a person coming up to me at conference or something that I'm speaking at or get an email that is a person in recovery saying, "I told them I'm in recovery. I told them they've got to give me something different than these pain medication." And almost every time the story is, "They told me I had to take this medication while I was going through this."

So the person does it, and then they are now back on these medications and struggling to get back off of them with no help then from the whoever did the surgery or the physical condition because that person doesn't get what they've just asked this person to do. They've just asked this person in recovery to start using, if you will, in order to get through a physical health condition.

So this issue, and Charlie raised it first, of other approaches. I just don't think we collectively, and I say that in the broadest sense -- the health, behavioral health. If we could get a surgeon to say I need to get a consult with a substance abuse -- a well-qualified, well-thinking substance abuse provider who could help me think about how to work with this individual who's in recovery that we don't want them to get off the wagon, if you will, again. So --

DR. STEPHANIE M. LE MELLE: Just I think we should clarify. It's not the surgeons. It's the anesthesiologists. The surgeons are not the ones that are using the pain meds, and they're not the ones who are putting people on the meds. It's the anesthesiologists. And I think that specifically targeting that group is really, I think, as opposed to just sort of broadly targeting, the anesthesiologists are the ones that are prescribing a lot of the high-dose pain meds.

MS. PAMELA S. HYDE: Actually, I don't know who it is, but I can tell you this is one of the issues -- this is one of the reasons ASPE was asked to do this data because everybody has their own opinions. It's the dentists who are prescribing

all this. It's the vets who are prescribing all this. So I don't even remember what the data is, but the ASPE was doing the data about who is prescribing all this because everybody has kind of their own opinions about who's doing it the most.

And apparently, what the data said was like totally -- dentists are one of them, but it wasn't quite as what everybody sort of thinks either. But that's a good point. It's who is it that's doing this? And I don't ever think that it is somebody trying to get a bunch of people hooked.

I think it is not understanding what they may be doing. Yes, Ben?

DR. BENJAMIN SPRINGGATE: Ben Springgate.

Thank you both for these presentations, and I've appreciated the comments that we've heard so far.

One of the thoughts that I had as I think about your experience, Cassandra, and pain management options is that it's while there are increasingly -- at least in our area, there are well-run pain management options that are becoming available, many of them don't take Medicaid at all. Many of them are cash only and which is a problem we have in psychiatry in our community as well.

So that's one of the challenges. I would point out that I agree. It's probably lots of folks, in addition to dentists and anesthesiologists, that are responsible for some of this. I'm glad that ASPE is looking more closely at that data. I wonder if there may be a couple of options to helping to get like maybe opioidprescribing.com or related educational programs more widely disseminated. I noticed that you had some webinars with these major professional organizations.

I was at the American College of Physicians, which is internal medicine, principally general internists, in San Francisco earlier this week that got chapters in each State. The national meeting is once a year. It was this week. The American Academy of Family Practice has its meeting in Kansas City, Missouri, every year. So there you get -- and then they have chapters in every State as well. So those may be options.

And then I believe, if I'm recalling my California licensure correctly, that you have to have hours for California licensure. And I'm not licensed in every State, but Louisiana is the other State that I'm licensed in, doesn't have that requirement, and I'm not wondering how many States do or might be open to such a thing.

To get your medical license renewal, you have to attest that you have done X -- 10 hours in California -- number of hours in pain management continuing education among all of your continuing education. So there is, I mean, on the one hand, even the surgeons are going to push back, right? You know the one

that you met on the plane is going to push back and say, "You're going to give me another regulation? I have to do how many more hours of continuing education at this point?"

But the flip side is that from a public health stance, if we can get those types of broader availability, have it be free at these conferences or these training programs, even for the State organizations or the major hospitals and communities,. And then, ultimately, if that's not effective, then also integration into the licensure process may be another mechanism.

MS. PAMELA S. HYDE: Actually, this conversation is really interesting because there was a possibility of a piece of Federal legislation that would require all physicians to have certain number of hours in order to prescribe pain medication. That didn't even get onto the block to be drafted because within the executive branch, there wasn't agreement about -- I mean, who's going to take that on at a national level to try to make sure that every physician who wants to prescribe that medication has actually gone through the training?

So just monitoring and tracking that is like overwhelming, not to mention what the physicians think. And then there is the part of our organization who feels very strongly, our organization here, meaning HHS -- the broader HHS -- who feel very strongly that putting more constraints on physicians prescribing pain medications when they can't get enough physicians to do pain management for older people, for people with disabilities, for people with chronic pain issues.

So there is -- there is this cautionary policy debate not actually even in the full light of day yet, because we're just struggling with it, about how do you balance making sure that any constraints you might put on this in order to manage the overprescribing doesn't put additional constraints on the underprescribing that is thought to be equally of concern. So --

MS. CASSANDRA PRICE: This is Cassandra Price.

And I think it's important, too, that we're talking a lot about the physicians' responsibility and their role and them understanding addiction. But not ever losing sight of us educating the public about we talk about what is the appropriate thing for responsible drinking? We have a scale of what that means.

Well, what does it mean to responsibly take prescription medications? What is that standard? So people need to be educated about their healthcare and their needs. And so, when they go to the doctor, hopefully, they can advocate appropriately with a doctor that has a mutual understanding and take their medications as prescribed.

So I guess we never lose sight that we need to educate the public on their own healthcare needs.

MS. PAMELA S. HYDE: Yes. There's no question about that. And remember, as I said, there was one issue around prescribing, one around diversion, and one around appropriate utilization.

So, Betsy?

MS. ELIZABETH A. PATTULLO: Betsy Pattullo.

We have a program at Beacon called Psychotropic Drug Intervention Program, which sort of a kind of an affirmative model of getting data from our health plan partners on prescribing and then running it through algorithms, which I say that word without understanding what an algorithm is.

However, then trying to identify overprescribing or underprescribing for adults and for kids. And we've found there's been very, very positive results both in adherence, but also in education of docs about what's going on. And sometimes it's poly drug, you know, coming from different sources, but sometimes it's just people are not kind of aware of what the current guidelines are. So that's been pretty beneficial.

MS. PAMELA S. HYDE: Fran mentioned it when we were talking about the prevention part of this, but the number of individuals, I could say parents, but I don't think it's just parents, who don't think -- I mean, they wouldn't think to leave poison around when there are either, frankly, animals or young people who don't understand are going to get them. But they'll leave their prescription drugs sitting on the counter without thinking about what that means not just for young people, but for other people who may be able to access those meds.

So just teaching people that this is something you need to be careful about and you need to put it somewhere that's safe. And Fran?

MS. FRANCES M. HARDING: I was just going to say yes to all the last comments. This is truly -- I think one of the reasons why this has grown into such a large problem is because we have it all. It's the perfect storm.

You're dealing with parents that are just trying to do the right thing with their children. So if they have a prescription that their doctor gave them for their other child who got their wisdom teeth out, and then you have another child that ends up with a toothache, and you happen to have a couple of pills left over, you're going to give it to them because that's the cultural thing Cassandra was talking about.

But you also have the college student who is on Adderall and realizes that they are on Adderall for not staying up at night to study, but they have found, hmm, this helps. So their roommate is struggling. They innocently then pass that on.

So we have, and then you have the ones who gather the Adderall for selling purposes, and then that transcends into addiction, which turns into our population, not to mention everything we've said about the doctors.

So it's the public education. It's the interventions of people that are starting to use this inappropriately. It's the parents. It's the community. It's the kids. It's the docs. It's everybody.

So I think that we know -- the one thing we know, even though our data in SAMHSA does not bear out that it's growing, as a matter of fact, it's sustaining. And in some cases, like the 18 to 25 population, only because of the higher education piece, it is declining. But what is rising in just an alarming rate are deaths that are occurring to this. And that's why we're seeing the numbers that we're seeing from CDC is because of the overdose and the number of mortality is off the charts.

But Westley and I, the strategic initiatives, if you don't really understand how they work, there are times when you wouldn't know who works for Westley and who works for me on this particular topic. And one of the difficulties in doing this presentation is Wes has more things about prevention, and I say more things about treatment when we give the presentation.

So when we were asked to separate it, it was stumbling over because I didn't want to go over the information. But that's a good thing because then you've sort of made an efficiency of being able to send two people out to do the same work and all of our staff.

MR. CHARLES OLSON: Charles Olson.

I don't know how many pharmacies do this, but when I used to be on medication, when you got your prescription, they give you a little piece of paper, and you had to sign the bottom saying that you understand your dose. You understand all the side effects and stuff like that.

How hard could it be to just add something onto the bottom of that, "I understand this is the proper storage guidelines," or I mean, I understand there's a lot of variables with everything else. But I think the public education, there's a lot of kind of clever ways to get that out.

MS. FRANCES M. HARDING: And that's a very good idea. As a matter of fact, there is one State -- and I'll have to look it up for you -- that actually puts it on the receipts. So it's a similar process, but I like your idea even better because it forces someone to read it.

DR. STEPHANIE M. LE MELLE: I don't know if this is in other places, but I know in New York, there's a public health announcement that's coming on TV as a

commercial, and it's these kids in the bedroom, and they've got like the mom's prescription bottle on the bed. And they're sorting out the pills. And she peeks in the door, and she sees it, and then she says, "Oh, I was just checking on you. I'm going out to the store." And she walks away. And that's the public health announcement.

And I remember the first time I saw it, I was like wow. I don't know who put it out there, but I mean it was really powerful, and it says, parents, you need to be aware of what's happening to your prescription.

MS. PAMELA S. HYDE: It's Partnership, isn't it? I think it's Partnership for Drug-Free America.

DR. STEPHANIE M. LE MELLE: Okay. But it was really very powerful.

MS. PAMELA S. HYDE: Yes, and they're trying to say parents --- the message is trying to say parents don't get that this is a problem. Yes, if they saw their kids on the bed with marijuana they would do something about it. But yes. Yes.

MS. FRANCES M. HARDING: Stephanie, it's like the days of when parents would say, "I would much prefer to have my child drink in my basement than to take illicit drugs." It's sort of a similar kind of playoff on what's happening. That's why the cultural undertones here, they're very interesting.

DR. H. WESTLEY CLARK: And that's Fran's point. That you need a comprehensive strategy, and as others have pointed out, you need to educate everybody in that universe from the patient, consumers, to parents, to the pharmacists.

Our NSDUH data show that 75 percent of the people who misuse prescription drugs get them from friends and family. Eighty percent of the prescription drugs are written by an indexed practitioner for a single patient generally for an indicated purpose.

So you are going -- you've got to safe lock the prescription because of the PDP Partnership's advertisement. People don't see it as a problem. So I'm not misusing it. I'm the index patient. But I set it on the table, the medicine cabinet, on the bed stand for anybody else in the world to use it. So we've got a lot of work to do.

MS. PAMELA S. HYDE: So, Megan and Charles, we talk about this a lot in terms of youth. It's not always youth, but certainly I think there's some evidence that youth are testing, experimenting, whatever, with medications they get from family, friends, whatever. Do you guys experience this with your peer group, or do your kids, your colleagues talk about it? Do you talk about it at school, or what do you hear about this?

MR. CHARLES OLSON: Charles Olson here.

Most definitely. I think that there is a couple other things that play into effect. When people hang out at their friend's house or whatever. On top of that, prescription drugs are easier to steal. Stealing illicit drugs, kids keep a pretty close eye on that. You go to the bathroom. You search through the medicine cabinet, and you see what your friend's got. It's much easier to do it that way, too.

And I think there is just a general, just the general overall feeling that, well, if it was prescribed to so-and-so, it's okay for me to take. Yes, it must be safe. But yes, there's -- I've seen it personally. So --

MS. MEGAN GREGORY: I would just echo what Charles just said. I remember growing up, my dad was a heart attack patient, and so they would prescribe him Vicodin. But he was so sensitive, I mean, he couldn't even take baby aspirin. And so, it would just be on the shelf, and my parents, they never even thought about it.

But now looking back, I just realize how dangerous that is. And I know that I have had some friends who their parents had it, and they would take it if they had a headache, or they were just not using it right. So it's definitely an issue.

MS. PAMELA S. HYDE: Well, what do you think -- that comment raised for me. What do you think about -- because we try to think about ways that we can support positive images of the way people should deal with alcohol and drugs and other things. Immediately came to mind the House episodes, and you've got a character there who's a character in and of himself. And it has nothing to do with his Vicodin addiction, but he clearly is.

So I don't know if anybody watches that program. But do you think things like that are helpful or not helpful? I mean, basically, what you see is a guy who's addicted, and he's got problems because he's addicted. But he's also like really cool, and he like fixes everybody else's problems. So it's like what do you think about that kind of thing?

We don't take it on, but we do award -- we do Voice Awards every year that try to give awards to appropriate portrayals of mental health and substance abuse issues.

MS. CASSANDRA PRICE: This is Cassandra Price.

One thing I wanted to do in Georgia when Katy Perry's song came out, "Last Friday Night," I wanted to get a group of kids --

MS. PAMELA S. HYDE: Sing it. You've got it going, girl.

[Laughter.]

MS. CASSANDRA PRICE: I really don't. I really don't. But I wanted a group of kids to rewrite that song like clean and sober activities. But I couldn't get -- I was driving down the road trying to think, all right, what could I say besides -- so I mean, I think that there's so many messages out there, and how do you change that message to something more positive? But that's just -- that's my thought for the day.

MS. PAMELA S. HYDE: Yes, well, we have some information that tells us people don't even know the right amount of alcohol it's okay to drink, much less -- I mean, I guess you could say, well, no amount of illicit substances are okay to take. But when you think about it, as Charles said, that a doctor gave it to somebody, it must be okay. It's hard for people to think about that as not okay.

So final comment here?

MS. MEGAN GREGORY: I was just thinking it would be interesting to partner with the National Council of Young Leaders or the new Presidential Youth Council to partner and do PSAs just for social media and just having them talk about it and educating their peers about it. Because I think that you'll get further by having peers reach out to each other, and they'll be more inclined to listen.

MS. PAMELA S. HYDE: There's no question about that. Thank you.

All right. Good. This was a rich conversation. So thank you very much for that. Again, it always stimulates us to think about what we could do differently or better or whatever.

Agenda Item: Public Comment

So we have just a few minutes left, and our job at this point is to listen to the public. We've got -- do we still have somebody on the line?

Operator? Is it still Tanya?

OPERATOR: Yes, would you like to go ahead and take questions at this time?

MS. PAMELA S. HYDE: Okay. If we're going to take a question or a comment, we should let the public know that we would like them to hold it to a couple minutes, and so each comment, we can always come back to someone if there's more time. But without knowing exactly who is on the line, just a couple minutes

for a comment or question.

So, Tanya, could you ask if anybody's got one?

OPERATOR: Thank you. If you'd like to ask a comment or question, please press *, then 1. Once again, please press *, then 1. One moment, please.

[Pause.]

OPERATOR: And are you ready for the first one?

MS. PAMELA S. HYDE: Yes, go ahead.

OPERATOR: Okay. Sean Bennett has a question. Your line is open.

MR. SEAN BENNETT: [on telephone] Yes, hello. This is Sean Bennett calling. I wanted to make sure that everyone got -- I had a three-page fax I sent to Geretta a couple days ago that I thought was very pertinent and relevant to what the group is looking at, and the focus of my concerns has to do with drug quality.

And that I'm very concerned that SAMHSA would be encouraging pushing drugs on children, on the elderly, and on adults that would be very counter therapeutic and very hazardous to the health of millions of people. And I've seen this. I've been concerned for years, and I read the mission vision statement of SAMHSA, and I say it's looking as though they feel that it's their job is to convince people that drugs are effective, and I think this is a massive, massive blunder as a matter of policy.

And compounding this massive policy blunder is laws that force and coerce people to take these drugs against their consent, which, in my view, is nothing but assault, abuse, and a violation of our Constitution from beginning to end.

So I want these two issues to be something that this group, the advisory council, and SAMHSA can seriously look at as we're talking about the national dialogue. You want to help people? Well, we don't want to harm them, and when you have drugs that are going to be harmful and counter therapeutic for the majority of people on them, we definitely -- I feel like I'm talking right now to the Titanic going in the wrong direction. And so, I'm hoping that I can try to steer the Titanic so that it goes in the right direction again.

So, anyway, those are my two issues. Number one, try to make sure that informed consent is protected, that there's not forced drugging, and the laws and policies that are trying to force people on drugs that are dangerous are especially offensive to the Constitution. And I think that this group is uniquely positioned to try to modify, try to regulate, try to lead in terms of educating the public and educating policymakers that it's grossly illegal in the Constitution to be forcing

people to take these drugs against their consent.

So I encourage if there's anyone have any input, I definitely encourage that at this point. Thank you.

MS. PAMELA S. HYDE: Thanks, Sean. I really appreciate it.

We did, in fact, discuss your comment yesterday. You may not have been on the line when we did. So we discussed it at some length, and we had quite a bit of discussion yesterday about different opinions about that. And it's sort of interesting that --

MR. SEAN BENNETT: Well, I did miss it. I know you --

MS. PAMELA S. HYDE: Sean, let me finish.

MR. SEAN BENNETT: Go ahead.

MS. PAMELA S. HYDE: Sean? Sean, let me finish. It's interesting that you have that perspective. There are certainly other people out there who have the perspective exactly the opposite, that SAMHSA should be doing more to encourage forced treatment. We don't believe either one of those.

We think there are some people who are heavily overmedicated and shouldn't be. We think there are some people who don't get access to the appropriate medications they need, and we're trying to make sure that people get the right treatment at the right time with the consents that are appropriate in law.

So that is our position.

MR. SEAN BENNETT: Okay. Well, can you still hear me okay?

MS. PAMELA S. HYDE: Yes.

MR. SEAN BENNETT: I regrettably missed -- after you read the question I sent in yesterday, and then there was a break. And then I missed it. I had to do something else. So I may well have missed the discourse on that.

But the point was the proper duty of SAMHSA as being -- to me, it's almost aiding and abetting a fraud to try given the state-of-the-art, current state of science of these antipsychotic drugs and these other ones, mood stabilizers and anticonvulsants, the science, the state-of-the-art of these drugs, they're so bad.

Maybe another thing that could be done through this group to try to help lead is from the pharmaceutical companies trying to produce a better, safer product. Something that's much less harmful, that's much more therapeutic. That would

be a great step forward, I think, is just to recognize that the current quality of the drugs are unacceptable. They're no good.

I mean, I would feel like -- I would be reluctant to feed this to my pet, these drugs. In fact, if you look at the science, they've given these drugs to animals, and they know they're toxic to animals. And I'm not making this up.

And when you know drugs are toxic to animals and when you know they shrink the brains of animals and cause brain damage to animals and all sorts of terrible effects, we know that they kill the elderly. They give these drugs to elderly. And within a month, many of them many times they die from these drugs.

I mean, this is criminal. Pushing these drugs on the American people is criminal, and then combine it with the coercion through laws that force people to take it against their informed consent, it's even more criminal.

And so, anyway, this is my opinion, and my goal is to -- hopefully, my statements are for the record. I hope that you have my three-page document, everyone sees it, and it goes in the record. That's all I can do is get it up for discussion and hope that in this time where we're looking toward this national dialogue that these issues are talked about and recognized as we commence this national dialogue.

So that's my hope. Thank you.

MS. PAMELA S. HYDE: Thanks, Sean. We do have your paper. So thanks for your comment.

MR. SEAN BENNETT: Thank you.

MS. PAMELA S. HYDE: Are there other comments, Jason?

[No response.]

Agenda Item: Closing Remarks and Adjournment

MS. PAMELA S. HYDE: Okay. Thanks to everybody from the advisory council for being here, and thanks for sticking around on a Friday. I know that may have an implication for you getting home. We really appreciate all your input.

And as I've said before, it stimulates us to think a lot about the work that we're doing, and we've got lots of ideas about next steps for the next meeting. And we'll see you in August, and some of you we may be touching base with before then.

So thanks a lot to everybody. Safe travels.

[Whereupon, at 3:10 p.m., the meeting was adjourned.]